INTERNET-BASED FAMILY THERAPY FROM
THE PERSPECTIVE OF THE THERAPIST:
A QUALITATIVE INQUIRY

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ABSTRACT

The purpose of this qualitative, phenomenological study was to learn more about the process of Internet-based Family Therapy and to discover the advantages and disadvantages of using Internet-based Family Therapy as part of a practice. The overarching question asked, “How do therapists experience the phenomenon of Internet-based Family Therapy?” The sub-questions were: (1) How is Internet-based Family Therapy defined by therapists claiming to do it? (2) What are the presenting issues for Internet-based Family Therapy going forward? Heuristic Inquiry was used for data collection and analysis. Five participants were interviewed using online text-chat. Each participant had experience doing Internet-based Family Therapy and appropriate credentials. The core themes discovered were as follows: (1) The sites may be deemed not truly therapeutic. (2) The use of video is highly recommended in Internet-based Family Therapy. (3) More severe clients are contraindicated for Internet-based Family Therapy. (4) Face-to-face Family Therapy is better than Internet-based Family Therapy, however Internet-based Family Therapy is better than nothing. (5) The use of theory in Internet-based Family Therapy is much the same as in face-to-face Family Therapy. (6) The main concerns with Internet-based Family Therapy are confidentiality, crossing state lines & harm to self. A final interview dealt with Ethical dilemmas in Internet-based Family Therapy, Internet-based Family Therapy standards, limitations of Internet-based Family Therapy and handling harm to self or others when doing Internet-based Family Therapy.
Therapy. The findings are discussed, as well as considerations for therapists and directions for future research are suggested.
DEDICATION

This dissertation is dedicated to Dr. John Zarski and Dr. Patricia Parr.
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CHAPTER I

INTRODUCTION

Chat rooms, personal home pages, e-mail, bulletin boards, video chat, list serves, blogs, newsgroups, instant messaging, and podcasts are concepts that were unknown to most people fifteen to twenty years ago. Today, these terms are commonplace. The Internet has become an almost incomprehensible reservoir of information. One can type in a search term on a myriad of search engines and information on virtually any subject imaginable becomes available. However, the Internet is not only a source for information, but it is a means of communication using a multitude of methods.

In the family therapy field, Internet-based Family Therapy is new enough that a common response to the idea is immediate skepticism. On the other hand, it is established enough that it occurs all across the United States and in many countries (Derrig-Palumbo & Zeine, 2004). Some cynics will purport that Internet-based Family Therapy is unsafe, creating an unneeded risk for breaching confidentiality. Others will also point out the obvious disadvantage of therapists not being able to read non-verbals. Some lament the use of Internet-based therapy, wondering why people would want to replace in-person therapy with new technology. Derrig-Palumbo (2002) challenges that idea by saying, “Nearly everyone in the field will say that Internet-based therapy is not intended to replace traditional therapy – the goal is to enhance it” (p. 20).
One of Internet-based therapy’s main benefits relates to people who would normally not have access to face-to-face (F2F) therapy. People who are less likely to go to a therapist’s office include agoraphobics, the elderly with transportation and/or mobility issues, bed-ridden people, shut-ins, people with disabilities that impact their mobility, people living in rural areas, military personnel, and parents with special needs children (Derrig-Palumbo, 2009; Scott & Thompson, 2009b). All of the people listed above might find Internet-based therapy more beneficial than F2F therapy. Even people that go to a therapist in person may not want to miss a session while on vacation, or individuals who move may not want to change therapists and would rather continue sessions on-line, through Internet-based therapy. According to Derrig-Palumbo, (2009) Internet-based therapy is only meant to be an additional option to enhance accessibility.

Because of changing technologies, it is incumbent upon marriage and family therapists to understand how Internet-based Family Therapy can be utilized professionally in ways that can most benefit clientele. The Internet is “at its core, a medium [italics added] of communication for electronic devices” (Bell, 2007, p. 445). “It is important to remember that online therapy is a medium by which psychotherapy services are delivered – it is not a new theory or approach” (Jones, 2009, p. 39). “Rather than griping about how this new medium seems to fall short when compared to face-to-face contacts, [we should be asking], ‘How might we use this medium differently to [sic] successfully and effectively do those things we find essential to the therapeutic process?’” (Scott & Thompson, 2009b, p. 33).

Many Internet-based therapy sites have been developed in the last several years, some by businesspersons with no therapy background and others conceived and
developed by therapists. A growing number of people first search the Internet for causes and treatments of complaints before consulting a health care professional. “Internet-based therapy fills a very prevalent market need for convenient and discreet access to mental health services” (Derrig-Palumbo, 2009). A computer can act as a ‘technological bridge’ between patient and therapist (Van Diest, Van Lankveld, Leusink, Slob, & Gijs, 2007) “Clinicians should be prepared to be leaders in on-line mental health care and information provision, as they will undoubtedly be looked to for leadership by their clients, whether they volunteer for such duties or not.” (Bell, 2007, p. 454) Jones (2009) notes that clients are demanding Internet-based therapy more frequently and therapists are providing it more often.

Research is called for to help therapists make informed decisions (and judgments) concerning the use of the Internet as a therapeutic modality. There is a paucity of research or literature on the topic of Internet-based therapy (i.e. few formal studies), and even less information about Internet-based Family Therapy (Scott & Thompson, 2009a). “Remarkably little empirical research has been done on the use of Internet-based therapy or allied treatment modalities” (Van Diest et al., 2007, p. 117). It is difficult to find literature that helps the reader understand exactly the form of Internet-based Family Therapy and how it is unique from individual Internet-based therapy. Much of the literature that will be discussed in Chapter II leans toward individually focused concepts and practices. One hope of this study is to broaden the literature for Internet-based Family Therapy.
**Professional acceptance and governing bodies**

Therapy by indirect means (e.g. letter, telephone, etc.) has been used and accepted by clients since the days of Freud, and found to be effective (Skinner & Latchford, 2006). “The delivery of mental health services is commonly referred to as online therapy, and has been practiced since the early days of the Internet” (Derrig-Palumbo, 2009, p. 24). Dr. Albert Ellis has used Internet-based therapy to meet with clients all over the world (Derrig-Palumbo). “Health care technology leaders in the U.S. envisioned telehealth over 40 years ago as a means to improve access to health services for rural, underserved, and isolated populations” (Kazal & Conner, 2009). In the last decade, even the U.S. government has made notable investment in the development of telehealth networks, including systems like the Main Telemedicine Services & Arizona Telemedicine Program (Kazal & Conner). Improved reliability and lower cost of equipment have also helped the growth of Internet-based therapy.

The medium of Internet-based therapy is relatively new. Because of this, many governing bodies have not developed statements on how to deal with the matter, but there are some organizations that have created ethics codes related to Internet-based therapy. Currently, some states and professional organizations have directed members to their existing code of ethics, while others have established guidelines specifically for Internet-based therapy. There is now an International Society of Mental Health Online (ISMHO) made up of mental health professionals (Skinner & Latchford, 2006). The National Board for Certified Counselors issued Standards for the Ethical Practice of Webcounseling in their Fall 1997 newsletter. The Association for Counseling and Therapy Online has a professional conduct statement (2011). There are also Guidelines for Mental Health and
Health Care Practice Online (2011). There is a need for continued development of Internet-based Family Therapy standards.

In July of 2012, the marriage and family therapy professional organization, The American Association for Marriage and Family Therapy (AAMFT) added two subsections to the code of ethics that dealt with electronic therapy and the protection of electronic information.

1.14 Electronic Therapy. Prior to commencing therapy services through electronic means (including but not limited to phone and Internet), marriage and family therapists ensure that they are compliant with all relevant laws for the delivery of such services. Additionally, marriage and family therapists must: (a) determine that electronic therapy is appropriate for clients, taking into account the clients’ intellectual, emotional, and physical needs; (b) inform clients of the potential risks and benefits associated with electronic therapy; (c) ensure the security of their communication medium; and (d) only commence electronic therapy after appropriate education, training, or supervised experience using the relevant technology. (AAMFT, 2012)

2.7 Protection of Electronic Information. When using electronic methods for communication, billing, recordkeeping, or other elements of client care, marriage and family therapists ensure that their electronic data storage and communications are privacy protected consistent with all applicable law. (AAMFT, 2012)

Previously, they had posted several articles on their website (originally published in Family Therapy News – 1995 & 1999). They also dedicated a Family Therapy Magazine issue (2009) to issues related to Internet-based Family Therapy. These articles discuss issues such as confidentiality when using electronic media. In one article, O’Malley (1995) addresses the specifics of situating computer screens in the office, storing disks with case notes on them, informing clients of potential confidentiality risks when using cell phones. These efforts of creating Internet-based Family Therapy standards are a good start, but more work is needed.
In another article, Haug (1995), discusses issues related to telephone therapy. Although Haug acknowledges that telephone therapy gave access to others who may not otherwise have it, the article focused on ethical conflicts. Haug mentions the absence of nonverbal signals necessary for assessment and treatment planning might be problematic. She also raises the concern that clients choosing this medium might be less likely to want long-term therapy, necessitating the proper training in short-term and crisis counseling. The issue of interstate phone therapy was discussed mentioning ethical issues such as duty to warn when different states have differing laws. Informed consent, billing policies, etc. were also addressed, again, basically reiterating concerns found in the literature (Haug, 1995). Haug reiterated some of these issues in a 2009 article in *Family Therapy Magazine* (discussed more in detail in Chapter II).

Stanley (1999) states specific issues that are seen as ethical challenges: no establishment that intake and assessment could be done properly on-line, no non-verbals (body language and tone of voice), possibility of dishonesty regarding client’s ID, risks to confidentiality (intentional or unintentional transmission to other parties), difficulty in assisting clients with emergencies, and difficulty in protecting third parties that the client has threatened to harm. Another concern this article raises is that third-party reimbursement and liability insurance might be difficult to obtain (Stanley, 1999). It would be wise for anyone considering the practice of Internet-based therapy to check with his or her malpractice insurance to see if it would be covered (Jencius & Sager 2001). Since there has been a change in legislation that allows insurance to reimburse on-line mental health care delivery, more people are likely to utilize this mode of therapy (Dougan, 2002).
The American Psychological Association (APA) has a statement (1992) on their website (http://www.apa.org/ethics/education/telephone-statement.aspx) regarding services by ‘Telephone, Teleconferencing, and Internet.’ They refer members to their “Ethical Principles of Psychologists and Code of Conduct” instead of establishing any guidelines specifically about Internet-based therapy. APA refers to the boundaries of competence and states that if there are no standardized training modes, then the psychologist needs to take reasonable steps to make certain that they are competent in the given area. APA also mentions standards of assessment, structuring the relationship, avoiding harm, informed consent, fees, and advertising.

The American Counseling Association (ACA) Governing Council approved a set of guidelines for on-line counseling in October of 1999 and updated in 2005. Not surprisingly, many of the issues already written about above are addressed in the guidelines. The following is a summary of their principles: Counselors inform clients of the limitations of confidentiality related to on-line counseling, use a secure site and the proper encryption software, and only give out general information from non-secure sites or e-mail. One specific issue that was addressed in these guidelines was whether counselors should provide encryption software and if so, would there be a charge for it. Counselors should inform clients if other professionals will have access to their information (e.g. supervisors). Counselors verify the client’s identification and make sure to have other means to contact clients for emergencies. Counselors should have the clients sign a waiver/informed consent and if they refuse, clients should be referred elsewhere. Counselors should maintain records in a method that will insure confidentiality. The counselor is responsible for transferring data to authorized third
parties using secure methods. Counselors ensure through a procedure that on-line counseling is appropriate for the client. Proper treatment plans need to be developed. Counselors give clients appropriate contact information (e-mail, cell phone, emergency hotline, etc.) and times to be reached. Counselors verify the age of the client and make sure that minors have parental consent. Counselors make sure that they are covered by liability insurance for on-line counseling. Finally, the ACA governing policies state that since counselors must not practice outside areas of expertise, they do not provide on-line counseling to clients in other states in which they are not licensed. This ACA statement seems to be the most direct of any set of standards, especially because few therapists would have direct, up-to-date knowledge of the different sets of laws for each state. However, this stance might be questioned and challenged legally because many therapists assume the site of therapy is the place where the therapist is located.

*Purpose of the Study*

Internet-based therapy is gaining popularity, but there is a lack of research on the subject (Van Diest et al., 2007; Scott & Thompson, 2009a). “Research into this area is scant and sorely needed” (Negretti & Wieling, 2001, p.290). Because there is a lack of research, most therapists that use Internet-based therapy are using theories and interventions developed for face-to-face therapy in the office setting or in-home therapy. There needs to be a comprehensive accounting of the positive and negative aspects of Internet-based therapy and especially Internet-based Family Therapy. The current study addressed the paucity of research in the area of Internet-based Family Therapy through the lens of practicing on-line therapists.
The purpose of this study was to learn more about the process of Internet-based Family Therapy and to discover the advantages and disadvantages of using Internet-based Family Therapy as part of a practice. It is hoped by the author that this study is informative to those that are unacquainted with Internet-based Family Therapy. In the last few years there have been a few studies related to Internet-based therapy, but there are still relatively few and those that have been done do not focus on family therapy (Anderson, Spence, Donovan, March, Prosser & Kenardy, 2012; Button, Wiles, Lewis, Peters & Kessler, 2012; Dear, Zou, Titov, Lorian, Johnston, Spence, Anderson, Sachdev, Brodaty & Knight, 2013; Spence, Donovan, March, Gamble, Anderson, Prosser & Kenardy, 2011; Van Diest, et al., 2007; Klein, Richards & Austin, 2006; Skinner & Latchford, 2006; Wagner, Knaevelsrud & Maercker, 2006). These studies will be discussed in further detail in Chapter II.

Today, there are only a small number of dissertations focusing on Internet-based therapy, which is evidence of the newness of the field. This research is similar to Haberstroh’s (2002), in that it was an exploratory study interviewing participants about their experience with Internet-based therapy. The main differences from the Haberstroh (2002) research were a focus on interviewing clients, therapists, and supervisors. This study solely focused on the therapists. The client and therapist participants in the Haberstroh study were student volunteers. The participants in this study actually have experience doing Internet-based Family Therapy as professionals, which added to the authenticity of the research.
Statement of the Problem

There are people conducting Internet-based Family Therapy and there is little known about the phenomenon and/or experience of the practice. There is a lack of knowledge and understanding of the phenomenon of Internet-based Family Therapy, how Internet-based Family Therapists define the practice and what their qualitative experience is.

Research Questions

The research questions are guided by current research in the field. The overarching question asks, “How do therapists experience the phenomenon of Internet-based Family Therapy?” The sub-questions are: 1. How is Internet-based Family Therapy defined by therapists claiming to do it? 2. What are the presenting issues for Internet-based Family Therapy going forward?

Subjectivities Statement

My definition of Internet-based Family Therapy is any therapy that occurs over the medium of the Internet and uses Family Therapy theories and techniques with families or individuals. This includes text, voice and video chats.

I became interested in Internet-based Family Therapy in somewhat of a roundabout way. I had completed a master’s degree in Marriage and Family Therapy and had finished most of my classes in my doctoral program (also in MFT). During this time, a friend of mine introduced me to Personal Digital Assistants (PDA). I had not been interested in PDAs, cell phones, pagers, etc. before and thought, “If people could survive for thousands of years before without these items, then why would I need them now?” I decided it was in my interest to get a PDA because I could schedule items into the
calendar and set alarms as reminders to myself. In researching software, I found a program that was designed to improve a person’s work as a therapist. This led me to my first idea for a dissertation related to technology – a study asking if a program could actually improve some aspect of work for marriage and family therapists.

I began my literature review and discovered that almost all of the literature related to therapy or counseling and technology of any sort was focused around Internet-based therapy. I was somewhat discouraged, because I thought that my idea for a study would not work. During this period, I went to the 2004 National AAMFT Conference in Atlanta and attended a pre-conference workshop called “Online Therapy: The new frontier” (Derrig-Palumbo & Zeine, 2004). This workshop, along with the fact that research was pointing in the same direction, led me to decide that research of Internet-based Family Therapy was the direction I wanted to take.

The school environment that I was in also influenced me. The University of Akron puts a high priority on technology. They tout a campus wide wireless Internet system as the first of its kind in the country. They require a high level of technological competencies throughout the program that I was in. Several classes I had were experimenting with on-line forums and/or encouraging use of certain computer programs to enhance learning experience of students.

In my research classes, there were quantitative and qualitative programs designed for increasing research productivity (e.g. S.A.S., S.P.S.S. – statistical packages, N-6 – a qualitative organizational program). I was also introduced to the advantages of doing research over the Internet. The school had a department that helped students develop on-line surveys for research purposes. The university’s influence, the literature pointing to
Internet-based therapy, and the workshop on Internet-based Family Therapy all persuaded me to do a study related to Internet-based Family Therapy.

The decision to do a qualitative study was not haphazard. In the past, I had leaned toward quantitative research because I like math and it seemed more neat and clean. I liked the idea that I could send out a survey and compile all the answers (automatically if done over the Internet), input the data, and have a program “spit out” my research results. Qualitative research seemed messy and impressed me as a long, drawn-out process. From the different research classes that I took, I understood that the purpose and question should drive the type of research. It became apparent to me that a study about Internet-based Family Therapy would need to be qualitative in nature because of how early it was in the process of research and development. The research at this point in time needs to be exploratory. It will involve a process of building theory (Merriam, 2001). The current study is not meant to build theory in and of itself, but is meant to be a catalyst for theory building in the field of Internet-based Family Therapy.

A dissertation that I read that was very much in line with my interests came from the same perspective and even claimed to build a grounded theory from the study (Haberstroh, 2002). One difference between what Haberstroh did in his study and this study is the methodology. The current research included interviews over the Internet. It was a more immersive experience allowing me more insight into the pros and cons of this medium for communication. I was able to have my questions typed out ahead of time and simply paste them into the chat window (of course, with the option to type more for follow-up questions), and respondents would type their answers back to me. The text-based chat eliminated the need to transcribe interviews and potential transcription errors.
Lastly and most importantly, I felt that it added to the richness of the study. Haberstroh (2002) chose to do his interviews in person saying:

If I were to have interviewed actual on-line clients, I would have had to utilize on-line methods, or telephone interviewing to collect the qualitative data. Thus, I would have conducted distance research on distance counseling. I believe that the participants described their experiences in more detail because I interviewed them F2F. I conducted a few on-line interviews with the participants and found that the on-line research sessions contained much less information than similar length F2F interviews (Haberstroh, 2002, p.10).

Looking at this quote, my thought was that if I did not believe in the validity of the medium (i.e. distance communication), how could I expect others to value the study? Getting less information from on-line interviews was a concern, but there were two reasons that I did not see it as much of a problem as Haberstroh (2002). One, my research participants were actual, experienced Internet-based Family Therapists instead of students performing Internet-based Family Therapy for a study, and I assumed that their experience gave them the ability to more eloquently and succinctly state their points. Two, related to the succinctness, I assumed that respondents might have given less information, but that the information that was given was higher quality (i.e. less ‘fluff’) and would add thick, rich descriptions that was a goal of the study. I could have chosen to do interviews face-to-face, but it would have been difficult and impractical to get a pool of participants that met my criteria that way. Also, I felt that immersing myself by using the medium being studied would be more engaging for me and hopefully, in turn, for the reader.

One of my initial concerns about Internet-based Family Therapy had to do with in- and out-of-state therapy. Some Internet-based Family Therapy proponents indicated that there are no legal problems with out-of-state clients because the therapy is seen as
taking place in the home state of the therapist (Derrig-Palumbo & Zeine, 2004). However, the literature warns that therapists need to be careful because of duty to warn and emergency help issues (for a more in-depth discussion, see Ch. 2). In learning about this issue, my bias came in to play because I would not want to have any clients outside of my own state. For the reasons mentioned above, I did not want to take a chance that I or others could be sued and I would not want to memorize (or expect others to memorize) the individual laws for 50 states (and/or any other countries) and verify solid emergency contacts for each client location if needed. There is a continued issue of possible conflicting states’ laws related to the duty to warn versus confidentiality. DeeAnne Nagel (2011) suggests bypassing these issues by simply practicing within state lines. I obtained my PhD in Ohio and I practice in Tennessee, so I inquired about the ethical laws for each state. As of March 22, 2013, the Ohio Counselor, Social Worker & Marriage and Family Therapist Board had added a section titled “Standards of practice and professional conduct: electronic service delivery (internet, email, teleconference, etc.).” It states that anyone practicing electronic service delivery to Ohio citizens “shall be licensed in Ohio” (p. 38) as well as some other issues like an initial face-to-face meeting (which may be by video) to verify identity, a proper informed consent, etc. Tennessee’s rules were most recently revised in 2009 and include a section that states therapists shall comply with the Online Ethical Advisory Options adopted by AAMFT.

Dissertations

As is evident in the literature review, there are few Internet-based therapy articles published at the time of this study. There are about twelve dissertations that seem germane to this study. A 2009 (Reynolds) dissertation looks at the difference between
F2F and on-line text-based therapy and how that impacts alliance with the therapist. The researcher determined that Internet-based therapy has some promise as a legitimate means of conducting psychotherapy. A similar study looks at customer satisfaction between Internet-based therapy and F2F therapy (Olson-Davidson, 2009). The researcher compares Internet-based therapy, F2F and a combination of the two and looks at the satisfaction of clients from the three groups. Olson-Davidson find that the Internet-based therapy group show significantly higher satisfaction than the F2F group. Three dissertations deal with internet-based college counseling centers (Brown-DiThomas, 1999; Howard, 2003; Waters, 2001). Two of the dissertations have to do with ethical concerns as they related to Internet-based therapy (Plunkett, 2004; Wehrman, 2004). Some researchers look at on-line mental heath services in a more general way, such as how many therapy websites exist or how many internet-based therapists are licensed (Slavich, 2003; Dougan, 2002). There are only two dissertations found that have a more substantial purpose and relation to this current study. One studies the process and outcome efficacy of on-line counseling (Bogardus-Groble, 2002). The other purposes to create a grounded theory of relating therapeutically on-line (Haberstroh, 2002).

Delimitations

All of the interviews for the study took place on-line. Considering that the focus of this study was about on-line activity, it made sense to interview therapists experienced in using the Internet. Just as in Internet-based therapy, there would be a lack of non-verbal communication during the interviews. One advantage being that the sample could be a national pool. The participants could be from anywhere in the country.
Another limitation was that all of the interviews were text based. Voice and video conferencing were excluded. These are methods used by some for Internet-based therapy, but they do not represent the primary way Internet-based therapy currently takes place. Currently, a majority of Internet-based clients prefer the chat modality over others (Jones, 2009). As time passes, voice and video will increase in popularity and should be studied within the context of their modality.

Terms

There are several terms related to the subject of Internet-based therapy that need to be defined. Some of these words come from different sub-fields (e.g. counseling, psychiatry, social work, family therapy, etc.). Some of the terms have similar meanings and are used interchangeably throughout this paper:

F2F: An abbreviation for face-to-face therapy.

Telephone counseling: Counseling over the telephone that is in-depth and occurs over a long period of time and is regularly scheduled with pre-arranged sessions (Rosenfield, 2002).

Telemedicine/Telehealth/Telepsychiatry: These are terms that some articles use referring to the practice of mental health or other medical practices over physical distances with the aid of some form of technology. There are several other terms that have the same basic meaning. The reader may see different terms, such as online therapy, depending on which article is being referenced. The current study refers to the phenomenon as Internet-based Family Therapy.

Synchronous communication: Communication that occurs in real-time (Finn & Banach, 2002; Jencius & Sager, 2001). In other words, there is no waiting for a response.
Examples of synchronous communication include instant messaging (IM), chat, telephone, and videoconferencing.

Asynchronous communication: Communication that occurs when there is a delay period between messages from the sender to the receiver and back (time-shifted) (Finn & Banach, 2002; Jencius & Sager, 2001). Examples of asynchronous communication include e-mail, regular mail, text messages, pagers, voice mail, and video e-mail. Both synchronous and asynchronous can be text, audio, or audio/video based. There can be a mixture of text and audio or video. A therapist could be doing a session in his or her office and request that the client(s) type out a list of priorities into an IM chat window being used simultaneously. This would be a good example of how one method can augment another form of therapy (Jencius & Sager, 2001).

Digital divide: A term that illustrates a divide between people with access to the Internet (even computers in general) with those that do not. People without access are stereotypically older, less affluent, less educated, less proficient and less confident than the younger, affluent, and educated mainstream population (Opalinski, 2001). It is important to understand the digital divide, if any, in the Internet client population.

Summary

Technology as it relates to Family Therapy is advancing quickly. Family therapy is already taking place on the Internet (Jones, 2009). There is little research in the area of Internet-based therapy and even less specifically about Internet-based Family Therapy and that needs to be remedied. Without this research, practicing Internet-based Family Therapists are using theories and interventions developed in an office setting without any empirical evidence that they are effective in this new medium.
Governing bodies have acknowledged the need to address Internet-based Family Therapy, but have yet to do so adequately. AAMFT (2012) has created specific guidelines related to Internet-based Family Therapy, and there is room for growth for these guidelines. The objective of the current study is to bolster research in this area, make the Marriage and Family Therapy community at large more aware of it, and encourage a level of standardization regarding ethical and legal issues for Internet-based Family Therapy.

The study used on-line text-based communication with a sample pool that was not limited to one specific region of the United States. The specific goals for this study were to find out how family therapists experience the phenomenon of Internet-based Family Therapy as well as seeing their view of what Internet-based Family Therapy actually is.
CHAPTER II

REVIEW OF THE LITERATURE

The mental health field is still in the early stages of the Internet-based Family Therapy phenomenon. The reader will see in the literature review that there are two main types of articles on the topic of Internet-based Family Therapy. One type of article focuses on the idea that there is an underserved set of clients that can access therapy through the Internet, but would otherwise be getting no therapy at all, thus considering Internet-based Family Therapy as a positive phenomenon. The other type of article focuses on potential pitfalls of the medium (i.e. ethical & legal risks). However, these authors typically lack actual experience or hard data to back up their claims. Therefore, there is little literature that provides a clear sense of the form and process of family therapy over the Internet (e.g. who is involved in the session, how many sessions are typically involved, structure within the session, etc). There is also scant reference to the experience of the people involved in the actual process of therapy over the Internet.

In this chapter, there will be three major components. First, to give the subject a context, the general process of Internet-based Family Therapy will be shared. Second, a presentation of the current literature on the subject will be provided. It will be important for the reader to keep in mind that most of the literature simply raises concerns because there is a lack of pertinent research to date, meaning that most of the articles referenced in this literature review are not empirical studies. There is a section titled Empirical
Studies to help make it clear which articles are from actual studies versus articles that give opinion on the subject matter. It is also important to note that any older references included are because of principles that do not change over time, whereas the technologies discussed advance as we move forward. Further, there are some earlier references to help give the reader a fuller understanding of the history and growth of technology as it has impacted the therapy field. Finally, a dissertation that attempts to create a grounded theory for Internet-based therapy will be presented. As mentioned in Chapter I, there is very little literature specifically about family therapy over the Internet. Some of what is reviewed in the literature may apply to families as well as individuals, but specific research on families needs to be conducted in the future.

The reader may not know much about Internet-based therapy since it is relatively new. He or she may think that it is interesting, but impractical and not likely to catch on as a viable means of therapy. Back in 2002, VandenBos & Williams said it is expected that Internet-based therapy will “become as routine, readily accessible, and expected as the telephone” (p. 492). Authors of articles suggest that Internet-based therapy is not in the future; it is here now. “Online counseling is no longer something that will take shape in the future. Right now, it is possible for a person to access the Internet, find a professional counselor, and have a session” (Mallen & Vogel, 2005, p. 761). Because Internet-based therapy is happening now and only expanding, we must continue to research by examining its effectiveness.

**Empirical Research**

As mentioned in Chapter I, researchers have conducted a few studies related to Internet-based therapy. But, there are still not enough and those that have been done do
not explicitly focus on family therapy. Some studies show promising results for Internet-based therapy for issues like panic disorder, phobias, anxiety and post traumatic stress disorder (PTSD) symptoms, but there need to be more robust studies (Bell, 2007).

Wagner, Knaevelsrud & Maercker (2006) conducted a study dealing with the efficacy of an Internet-based Cognitive Behavioral Therapy (CBT) program to help with complicated grief (explained further below). In fact, several CBT models have been tried on-line from a human therapist using the Internet to computerized therapies with little therapist intervention to totally computerized services (Bell, 2007).

Findings from Studies with Individual Clients

Of the few studies that have been done, there are some noteworthy and applicable findings. The reader should keep in mind that these studies are not about Internet-based Family Therapy. In a 2006 study, Klein, Richards & Austin found evidence for the efficacy of Internet-based therapy for panic disorder. They studied 55 people by randomly assigning them to either (1) internet-based CBT using e-mail contact, (2) a therapist-assisted CTB manual workbook or (3) only giving information by phone (the control group). They said the Internet-based treatment was more effective in reducing clinician-rated agoraphobia. Both the manual and Internet-based treatment were both found to be better than the control group. They used the Panic Attack Questionnaire, Panic Disorder Severity Scale, Anxiety Sensitivity Profile, Depression Anxiety Stress Scales, Agoraphobic Cognitions Questionnaire, and the Body Vigilance Scale for pre-, post- & follow-up testing, the Helping Alliance Questionnaire-modified, Treatment Credibility Scale-modified and Treatment Satisfaction Questionnaire for post-study and ADIS for DSM-IV for diagnosing as their measures. The assessors were blind to how
treatment participants were assigned (Klein, Richards & Austin, 2006). This study does not inform synchronous Internet-based therapy research because interaction between the clinicians and participants happened only via (asynchronous) email: “The program was interactive insofar as the therapists [sic] input: however, the program itself contained standardized instructions and information that did not vary according to participant input” (p. 220) (i.e. the main thrust of therapy in this study was a manualized treatment with encouragement from clinicians via email).

In another study, Wagner, Knaevelsrud & Maercker (2006) researched complicated grief with Internet-based CBT using a randomized controlled trial. They characterized complicated grief as chiefly having symptoms of intrusion, avoidance and failure to adapt. Total, they had 55 participants. These participants were diagnosed with complicated grief (using self-report on-line diagnostic questionnaires) and assigned to the treatment group or control waitlist. The treatment group was given exposure to bereavement cues, cognitive reappraisal & integration and restoration for their on-line treatment. The researchers used the Impact of Event Scale, Failure to Adapt Scale and the Depression & Anxiety subscales of the Brief Symptom Inventory for their measures. Wagner, Knaevelsrud & Maercker (2006) write that “participants improved significantly relative to participants in the waiting condition” (p. 429) and “the hypothesized improvements were observed in the expected time frame, indicating that the trauma and grief-focused modules of the program succeeded in addressing the symptoms targeted” (p. 446) and finally, “the patients experienced the Internet-based therapeutic relationship as strong and positive” (p. 448). The treatment group showed significant improvement with a “large treatment effect” (p. 443) compared to the control group with symptoms of
intrusion, avoidance, maladaptive behavior and general psychopathology (Wagner, Knaevelsrud & Maercker, 2006). One positive finding from their study that is applicable to the current study is that the participants did not come from a specific area, but rather they came from several countries because of the “worldwide accessibility of the Internet” (p. 433). One potential drawback of their study was their indication that complicated grief had not been studied in much depth (i.e. even face to face therapy), so there was no real baseline with which to compare their results. The current study is exploratory, so even though there have been many studies done on F2F therapy on a myriad of topics, the goal is more one of discovery as opposed to comparison, per se, although by the nature of the question “What is Internet-based Family Therapy like?” one cannot help but make comparisons to F2F therapy.

Although some studies are finding that a therapeutic relationship on-line can be strong, there are others, such as Haug (2009), in an article called *A View from the Sidelines*, that wonder if the therapeutic relationship would suffer in the on-line setting. Based on the literature, Haug contends that on-line clients were satisfied with treatment but not as much as F2F therapy. Anderson, et al. (2012) looked at the working alliance with Internet-based CBT for youth with anxiety and found that it was a predictor of outcome for adolescent clients.

Skinner & Latchford (2006) studied attitudes towards e-therapy with three different groups: current e-therapy clients, current users of Internet mental health support groups and current F2F therapy clients. The researchers wanted to see the difference in attitudes by having each group complete the Jourard Self Disclosure Questionnaire (SD-40) and Attitude to E-therapy Questionnaire. They could not measure the e-therapy
clients because they did not have enough participants from that group, so they compared attitudes from the other two groups. In the end, they did not find any significant difference in attitudes between 130 internet mental health support group members or 39 F2F clients. They reported that the F2F participants were more likely to be employed and slightly older. They did find that the F2F clients were more self-disclosing and less concerned about the anonymity of e-therapy, countering much of the intuitive though about Internet-based therapy. One of their conclusions was similar to the finding of the current study – Internet-based therapy is still in its infancy and not widely used. The researchers question why people in the study with positive attitudes related to Internet-based therapy do not actually engage in it.

A pilot study completed by Van Diest, Lankveld, Leusink, Slob & Gijs, (2007) looked at the efficacy of sex therapy through the Internet for men with sexual dysfunctions. They used a sample size of 39 for men with erectile dysfunction. The method for treatment was sex therapy exclusively using e-mail for a three-month period. Of those participants, fourteen percent reported improvement and seven percent reported continued improvement one month after termination. The researchers determined that sex therapy through the Internet could yield positive results and that the pilot study warrants further study (Van Diest, et. al., 2007).

There were other articles that looked at issues of Internet-based therapy such as differential response to Internet-based CBT (Button, et al., 2012), Internet-based CBT vs clinic-based CBT (Spence, et al., 2011), cost-effectiveness and long-term effectiveness of Internet-based CBT (Hedman, Andersson, Lindefors, Andersson, Ruck, & Ljotsson, 2013) and Internet-delivered CBT for depression (Dear, et al., 2013). The problem with
these studies is that they mostly focus on Internet-based CBT based programs that do not involve actual therapists, but rather a regimen of instructions.

A review of online therapy studies (Dowling, & Rickwood, 2013) only found six different relevant studies and they were all focused on individual work. As evidenced in this section, there is very little actual research on the topic of Internet-based therapy and almost all that exists is focused on the individual – as opposed to family. The remaining review in Chapter II is based off of literature that is not empirical in nature, but rather more opinion based.

The closest article that was available that dealt with couples was not an empirical study and it did not involve actual Internet-based Family therapy, but rather translating Integrative Behavioral Couple Therapy into a “self-help, web-based program” (Doss, Benson, Georgia & Christensen, 2013, p. 139).

*General Technology and Psychology Issues*

Some years back, Nielson NetRatings (2005) developed a tracking system for the Digital Media Universe (DMU). This DMU tracking combines internet applications and web-based traffic along with browser channel audience “including comprehensive measurement of AOL proprietary channels, instant messaging applications, media players, Internet Service Provider (ISP) applications (non-browsing), wireless content systems, web phones, news and information toolbars, connected games, weather applications, auction assistants and shopping assistants (http://www.nielsen-netratings.com/pr/pr_021121.pdf, p.1, 2010). The measurement amounts to the traffic across technology networks today. As of September 2010, the latest report from The Computer Industry Almanac (www.c-i-a.com May, 2009) states that worldwide internet
users topped 1.5 billion in 2008. The report stated that internet user penetration is now over 70% for the leading countries. It is safe to say that our society is replete with digital communication.

Given this viewpoint, people who have negative attitudes about or fear of computers (technophobia) is becoming a thing of the past. Smead (1999) did a study testing ‘computer attitudes’. Although the sample was biased (he used upper-level psychology students), he did find that their attitudes were rather positive towards computers (i.e. they were not afraid of computers). It would be naïve to think that there were not any people with some level of technophobia today, but even if there are, it does not nullify the potential benefits that Internet-based therapy could bring to willing individuals. Some clinicians are more comfortable with, and would rather rely on older technologies such as the fax machine and answering machines (Negretti & Wieling, 2001). So the question becomes, “Is the issue with the client’s comfort level or with that of the therapist?”

Enhancing Practice

There are myriad aspects of technology and its usefulness in the field of therapy. From using a word processor to doing session notes to keeping a schedule of clients to videoconferencing, various methods can be quite helpful in running a business related to therapy. History shows a process that we as humans go through when new technology arrives. Some people are skeptical and put off learning a new technology for as long as possible while others embrace it with open arms. Eventually, the new technology becomes more commonplace and early naysayers begin to assimilate it into their own lives. This process has important implications for Marriage and Family Therapy:
Marriage and family counseling using the Internet as a medium is a practice that has found its time and its generation. Historically, changes in counseling practice methods have come with great discussion and concern for the quality of the counseling provided. The reluctance of acceptance of new technologies is nothing new to counseling professionals. Our objections to technology have historically included the use of audiotape, videotape, and telephone counseling along with other now accepted practices in the field of counseling. (Jencius & Sager, 2001, p.300)

As an example, consider something as simple as e-mail. At first, many people were skeptical of e-mail and thought it lazy and improper compared to sending letters through regular mail (i.e. snail mail). It just did not seem as personal or as special. In addition, it took some amount of learning to figure out how to sign up for an account, log on, compose and send an e-mail. Now, the benefits of e-mail are more fully realized with advantages such as keeping in touch with old friends and relatives, shooting an e-mail to a colleague instead of using the phone, being able to share vacation photos or video without any cost other than internet access and a computer. It is also worth pointing out that it did not replace regular mail. This same process of acceptance occurs with any technology. To illustrate this, here are a few statements from people denouncing advancements in technology: Regarding the light bulb – “…good enough for our transatlantic friends ... but unworthy of the attention of practical or scientific men.” - British Parliamentary Committee, referring to Edison’s light bulb, 1878. Regarding the automobile – “The ordinary ‘horseless carriage’ is at present a luxury for the wealthy; and although its price will probably fall in the future, it will never, of course, come into as common use as the bicycle.” - Literary Digest, 1899. “The horse is here to stay but the automobile is only a novelty, a fad.” - The president of the Michigan Savings Bank advising Henry Ford's lawyer not to invest in the Ford Motor Co., 1903. Regarding the telephone - The Americans have need of the telephone, but we do not. We have plenty of
“messenger boys.” - Sir William Preece, Chief Engineer, British Post Office, 1878.

Regarding computers – “There is no reason anyone would want a computer in their home.” - Ken Olson, president, chairman and founder of Digital Equipment Corporation (DEC), maker of big business mainframe computers, arguing against the personal computer (PC) in 1977. As the reader can see, it is difficult to predict the future as it relates to technology. People often have negative reactions to new technology that is later assimilated into our everyday lives. My mother used to avoid the computer because it was confusing and hard to use, and now she runs her own business off of e-bay. My purpose in sharing this is to present the idea that Internet-based Family Therapy is one more piece of technology in this process of assimilation into our lives.

The practitioner should not forego using the Internet for service delivery just because the medium is new and the method of service delivery is still undergoing development...he or she just needs to understand that their professional duties may require them to consider different methods of protecting client files, records, communications, and confidences (Banach & Bernat, 2000, p. 160).

The computer is simply a tool that can be used to enhance the reach and effectiveness of the therapist. For years now, there has been an increasing union of technology and the field of psychology, therapy and counseling.

There are many examples of how technology has been used to enhance the practice of therapy as well as many examples of how technology has been used to buttress training of therapists. One example comes from the early 1980’s. Vinikoor & Perrault (1980) reported that 95% of alcoholic patients found videoconferencing easier than traditional meetings in a hospital. Fifty-five percent wanted to continue treatment through videoconferencing. These findings were partly due to the fact that the
videoconferencing made meetings more convenient and less time consuming. Some patients found that they were less intimidated through this medium.

One of the most important factors affecting the prevalence of computers is the expense of hardware and connectivity (to the Internet). The 1990’s saw a decrease in the cost because of the PC and low cost equipment (Mielonen, Ohinmaa, Moring, & Isohanni, 2002). The cost of computers has consistently decreased, while the quality and speed of computers has increased. Higher bandwidths for the Internet and more capable software show the increased quality of computers, resulting in clearer audio and crisper video feeds.

One complaint that has been discussed concerning the use of the Internet is what is known as “the digital divide” (Opalinski, 2001). This term refers to a divide between the haves and the have-nots – people with internet access and those without, such as the poor and/or elderly. However, the divide issue has lessened as time moves on. Most libraries have internet access now and there are also free dial-up services available from some companies, so money has become less of an issue (Murray & Fisher, 2002).

While the Internet has become so popular and widespread that it has past the point where it needs defining, justification of Internet-based Family Therapy is another matter altogether because of its relative newness. It is important that as marriage and family therapists, we stay current with the technology of the day. If we are fulfilling our duty to stay on the cutting edge, we may find that we are actually waiting for the technology to catch up to us. Even back in 2000, Zipper, Broughton & Behar said that “the rapid pace of development in the area of technology means that decisions about connectivity and equipment are sometimes made based on dated information. It has become apparent that
the capabilities of the technology lag behind the vision for its use” (p. 65). Ironically, this statement is ten years old, revealing the need for Marriage and Family Therapists to follow the pattern of technological advancement.

Better Understanding

The following sections are intended to help the reader better understand the concept of Internet-based Family Therapy better. Some of the examples given are from a pilot study done for the current study.

Internet-based therapy: an example

Before the discussion proceeds further, some readers may be asking, “Just what does Internet-based Family Therapy look like?” or “How is this different from (or the same as) therapy in an office?” So that the reader has a context for the literature review and an anchor for ideas, this section offers an example of an on-line text-based chat therapy session. The following is a passage from a booklet handed out at a pre-conference workshop at the 2004 National AAMFT Conference (particularly useful because it describes techniques being used in parentheses). Any typos are left in on purpose to show what a chat session can be like in real life. The reader should keep in mind that the following is an individual therapy session (not family therapy) and is provided as a means to help the reader gain an understanding of the process of Internet-based therapy:

T: Hello

C: Hi, I saw our bio in the therapist gallery and decided to have a session with you.

T: Great, what would you like to talk about today? (VALIDATION, OPENING LINE)
C: I have been depressed for a while now, and don’t have any motivation.

T: For how long? (INFORMATION GATHERING)

C: About 5 months

T: Tell me about your life five months ago. (INFORMATION GATHERING)

C: I broke up with my boyfriend 7 months ago and I was just fine, and then suddenly after couple of months, it hit me.

T: It hit you … (REFLECTING THE THOUGHT & FEELING)

C: Yes, like a brick, I thought I was ugly, fat, disgusting and no one would want me. I wanted to go back to him, but it was too late and he did not want me back. Now I stay home most of my time, I lost my job due to not concentrating right. I feel horrible.

T: Horrible, it must be very difficult for you. How long were you in the relationship? (VALIDATING, EMPATHIZING, INFORMATION GATHERING)

C: About two years. We spent all of our free hours together since we met. Even when I was at work I thought about the time I wanted to be with him. Now I don’t have him, I don’t have any one. What’s wrong with me?

T: You don’t have any one???? (reflecting the words that hold emotional weight to validate feeling, create therapeutic alliance and receive information)

C: Well, I have my family and girlfriends but I don’t have a man in my life.

T: Tell me about the role of a man in your life. (INFORMATION GATHERING)

C: I have to have a man in my life. Not for financial reasons, I pay for myself, I have always worked. Work has never been important though, I’ve been inrelationships [sic] since I was 15 years old, now I am 40 and this past 7 months are the longest time that I have been without a man.

T: And that means… … … … … … (OPEN-ENDED information gathering sentence)
C: It means that I am no longer desirable to men; I have not been able to interest any one for the past 5 months. I’ve lost the touch, the charm, the figure, the face, everything.

T: It must feel scary… (empathizing with client’s feelings)

C: YES, I am so scared, I am scared of being alone for the rest of my life, I can’t stand it, and I can’t live like that.

T: Can’t live like………… (utilizing client’s SENTENCE to gather information)

C: Like now, miserable, I have no one to get up for, to come home to, to cook for, to clean for, to dress up for. I have no purpose to live.

T: Do you have suicidal thoughts? (information gathering for CRISIS intervention)

C: NO, I am too much of a wimp to kill myself, I wish a truck would run over me and for me to wake up in a nice looking man’s buffed arm.

T: Interesting fantasy. Tell me about your other relationships… (naming the process non-judgmentally, SEEDING for the future, open ended information gathering sentence) (Derrig-Palumbo & Zeine, 2004, p. 29)

Based on the excerpt, it is evident that the therapist was able to validate, gather information, reflect, empathize, etc. Even though the client could not be seen (for non-verbal feedback), the conversation above has a fairly natural flow. There is also a lack of ‘filler’ discussion and the client went directly to the presenting problem. Advantages and disadvantages related to the process of Internet-based Family Therapy are discussed later in Chapter II.

The above excerpt is an example of Internet-based therapy being conducted, but it does not give the reader a clear picture of what it would be like to work with multiple family members on-line at once, nor does it show family therapy techniques in action. To address this concern, the researcher conducted a pilot study, part of which consisted of three family members acting as a family in therapy and the researcher acting as the
therapist. The following are some excerpts from that transcript that show examples of family therapy techniques (T=Therapist, F=Father, M=Mother, D=Daughter):

T: Daughter, if we were all sitting in the same room, say you were home for a visit, how might we all be arranged in our seating? (Structural, Experiential)

D: I could see me in the middle of my parents and you across from us

T: why you in the middle?

D: I don’t know, one of them on each side of me, in a sense pulling me in two directions

T: mom, dad, do you agree?

D: I don’t know how to explain it, that’s just what I picture

M: That’s probably accurate

F: I see me sitting on one side of mom and her on the other, with mom being a barrier between my input and our daughter

T: Do you think it would be a positive move if by the end of our time (however many sessions), that you would feel like mom and dad were sitting next to each other and daughter was, maybe a little off to the side in her own chair?

D: sure

F: Yes, good metaphor

M: I see her sitting between us BOTH loving her very much, not pulling her in different directions

D: I want to grow up and be on my own but I am a little scared about it and need to know they are there for me when I need them

T: What might we do in the next half hour to move a few inches in that direction?

T: Daughter, do you think mom believes you could get things done without her help? (circular questioning)

D: not really…

T: mom, do you agree with daughter?
D: sometimes she leaves me with responsibility but she does end up finishing things for me a lot. But I know its only because she loves me and wants to help me.

D: And my dad, well he never seems to want to help me with anything at all.

T: He thinks you’re capable. (reframe)

F: Right

The above examples were intended to show that family therapy-style interactions could occur using a text-chat based interaction. The question still remains whether these interactions happen during actual Internet-based Family Therapy sessions. This question is one of the motivations for the current study.

In addition to the mock session, there were two other portions of the pre-study. Below is a collection of quotes from an interview with the CEO of an Internet-based therapy Website company (mytherapynet.com) and the transcript from an on-line text-chat based interview done with an Internet-based Family Therapist as a test run-through of the data collection process for the current study. This information is provided to help the reader get a clearer understanding of Internet-based Family Therapy. The researcher’s questions are shortened to get to the essence of the material.

*CEO phone interview*

(R=researcher, C=CEO)

R: Are there actually people doing family therapy over the Internet – as opposed to individual therapy from an MFT perspective?

C: Yes they are.... and in many different ways

R: What does Internet-based Family Therapy look like

C: [One example would be that] you have one person who is being seen face to face. You add an additional family member who lives in a different state. The person who has been needing a family session with a parent, loved one and so on can now have effective interactions that include their therapist. [Another example is] the husband (or wife) who
is overseas in the military and is now coming home... They can begin interacting and working in couples sessions as the soldier is preparing to come home... We are doing this with the military in a pilot study presently.

R: Specific concerns?

C: One of the struggles that I continue to see is that the therapist forgets (lack of a better word) to use the same business practices that they use in person in the on-line setting. Continuum of Care. Since they are using a different approach there must be different guidelines to care... No...same guidelines just a different way of providing the care.

R: Any additional information?

C: Therapist prefer the webcam... Clients still prefer Chat. Chat sessions still tend to be much more effective. It does allow for more depth...People get to the root of issues... It goes back to...the face can give the other person a perceived sense of judgment.

C: Therapists are no longer in shock or want to tell me how wrong it is... They now want to learn how to do it...It finally has clicked...Therapists who contact me, or people who want me to write articles... now want to know...How do you do it? I speak all over the country and it is the same everywhere... The ones who are not interested are still not interested... The ones who think outside the box are even more interested and excited... The others who were always interested...are making more money and helping a group of people who would not otherwise have gotten the help they needed...

It should be noted that some research suggests that reintegration family therapy for soldiers (Bowling, & Sherman, 2008; Fals-Stewart, & Kelley, 2005; Ritchie, 2005) is not something that should take place while the soldier is still in combat.

Internet therapist text-chat based interview

(R=Researcher, T=Therapist)

R: What does Internet-based Family Therapy look like

T: The process involves one or several family members. Just as in face to face...You may only see one of the family members. This family member may be the IP or not. Same thing occurs in Internet-based therapy. What I have seen is that the client is able to get to issues much quicker. They feel a sense of freedom when it comes to speaking about other family members. They do not hold back as much as they do in face to face therapy.

R: Specific concerns?
T: I think one of the concerns is making sure the client continues their process and book more sessions. Often times they will have one session and not return or may take awhile to return. I believe this process occurs for several reasons. 1) The therapist is not explaining the process of therapy as well as they do face to face. (meaning discussing how many sessions may be needed and so on). 2) I think it is important for the therapist to realize that we are in a profession where we are not seen. It is, of course, all about the client. In Internet-based therapy we are seen even less. We need to be aware of that and not fall into a pattern or instances of self-disclosure.

R: Any populations contraindicated?

T: it is difficult if they are not high functioning. I think that any disorder that does not allow the client to be in a functional state would not work on-line.

R: What advantages/disadvantages?

T: Internet-based therapy is a medium in which therapy can be conducted. It allows people who would not otherwise go to get the help the need. Ideally, family therapy works beautifully in the office face to face with the therapist. However, this can not always be done. for several reasons. If one of the family members lives in another part of the state or country and is not able to come to therapy, Internet-based therapy now makes that happen for them. Family therapy is no longer at the mercy of the geographical location of its family members.

R: Any additional information?

T: I use on-line chat sessions with my clients in between F2F sessions. It is great for them...

Technology and Therapy

Therapy conducted over distances has been around since before the Internet existed by means of the telephone. Rosenfield (2002) writes about telephone therapy and how it is widely practiced in the United States. There has been a push to legitimize the practice in the UK. Rosenfield argues that emergency hotlines are already common and the people answering those phones are not trained therapists. Why shouldn’t therapists have the opportunity to do the same? Although phone therapy has become a viable option
for many therapists and clients, the focus of this research is on family therapy that utilizes a computer to communicate via the Internet.

One advantage of Internet-based therapy evident in the literature is how beneficial the use of a computer can be when giving therapy to children or adolescents. Teens and younger children often see the computer as novel. Seeing a computer simulation as a game makes young people less resistant and more open to the possibilities of change (Smokowski & Hartung, 2003) as it relates to therapy. Aymard (2000) did a study showing that the computer was a “hook” for children as opposed to a “turn-off”. As mentioned earlier, libraries (both school and public) offer internet access now (Murray & Fisher, 2002). This is one indicator that computers have become a normal part of life for the younger generation, and this population is more likely to be comfortable with the medium. As the above references indicate, technology may be a way to connect with children or adolescents, but the reader should take caution, because there is virtually no research indicating the efficacy of Internet-based therapy with children. Given this, there are unaddressed ethical and safety concerns.

Technology has not only been found to be beneficial to youths, but has also been found to profit older adults. Technology can mean new relationships, continued learning, facilitation of personal growth, an outlet for hobbies and new experiences or a way to redefine a career or a role; it can encourage increased life satisfaction and meaning and greater feelings of control, self-esteem, and self-efficacy. David Lansdale, an expert in geriatrics of Stanford University calls computers an “elixir” for older adults and writes that it helped the older adults overcome the “four plagues of institutionalized elders, including loneliness, boredom, helplessness, and decline of mental skills” (as cited in
Opalinski, 2001, p. 205). As these articles point out, there is potential for Internet-based Family Therapy to benefit people of all ages.

There have been many computer programs developed for work in the therapy field in the last several decades. Some programs are simulations for violence prevention, substance abuse prevention, improving attitudes about knowledge of health promotion, HIV/AIDS prevention, health information, dealing with eating disorders, phobias, or training. SMART Talk, SMACK, Health Hero, Life Challenge, CHESS, and BARN are some examples of programs developed for the mental health field (for further information see Smokowski & Hartung, 2003). Automated desensitization devices have been used and found to be as effective as therapists at reducing phobic behavior (Lang, 1980). Computers have been used to perform relaxation training as far back as the 1970’s (Cuthbert, 1976 [As cited in Aradi, 1985]). They have been used in just about every aspect of therapy including interviewing, assessment, and treatment (Aradi, 1985). Technology has helped individuals in other ways as well. Small computers have enabled non-vocal individuals to communicate in a therapeutic way (Yoshida, 1984).

As mentioned above, there were more than 1.5 billion worldwide internet users in 2008 with 235 million of those in the United States (Computer Industry Almanac, 2009). The Internet gets usage from all ages, races, and locations (Murray & Fisher, 2002). This has created a population for research much more diverse than the stereotypic college freshman introduction-to-psychology class sample.

Rosenfield (2002) recommends studying and exploring the possibility of using ‘net meetings’ as a way to consult with other therapists, to use text messaging with deaf clients, and find other innovative uses of technology. There is a plethora of possible
applications that must be explored in order to fully utilize these new resources. “Many authors see telepsychiatry as an innovation in clinical practice, although its origin can be traced back 40 years. The videoconferencing technique is well known in psychiatry, but the system whereby it is used has been studied very little” (Mielonen, et al., 2002; p. 187). There is still much to learn about Internet-based Family Therapy, and we as marriage and family therapists should lead the way in this journey of discovery. In 2008, Bee, Bower, Lovell, Gilbody, Richards, Gask & Roach did a meta-analytic review of articles about psychotherapy done remotely to see what articles are focusing on. They identified thirteen studies, most of which dealt with therapy over the phone, two over the Internet (text based) and only one by video conference.

Relative to other psychology-based fields, family therapy is fairly new. Family therapists are still seen as “wet behind the ears” because family therapy was established as a unique field a little over a half-century ago. When considering PCs, on the other hand, PCs that debuted only six months ago are thought of as ancient to the diehard techie. It is important to be cognizant of this dichotomy as papers are published focusing on technology and therapy. Yoshida published a paper in 1984 titled, “Microcomputer Technology and Related Services.” When this article was written, there were important items being addressed, but now most of it has become obsolete because computers have become much more advanced and powerful since then. Articles published yesterday may not be relevant today because there are continuously new innovations in technology, changing the view of limitations and the way people anticipate future possibilities. For example, not long ago, videoconferencing was not strongly encouraged because it was choppy and somewhat cost prohibitive for many people. In 2010, videoconferencing has
become quite commonplace because of decreased cost related to hardware and fast internet speeds. Additionally, it is becoming more and more common for web cams to be built into the monitor of desktop and laptop computers. Given the rapid advance in technology, it is not hard to imagine that in ten to twenty years time (or maybe less), there will be virtual technology widely available that will allow therapist and client to sit in the same ‘virtual room’ together, being able to see all body language and even shaking hands, all while they are physically half a world away from each other. Only imagination can limit the type of services that may be available in the future. It is important as one writes and reads articles related to technology to focus on the principles and process because it is almost certain that advancements will change the content.

*Computer Assessments*

One use of technology in therapy is computer-based assessments. One advantage of using technology for assessments is that computer assessments consume less time for the therapist and would simulate having the client(s) fill out paperwork in the waiting room. Clients could view the computer as a non-judgmental party and might be more likely to share information than in a F2F interview. A disadvantage to computer assessments is that there would not be any rapport-building taking place. Psychological testing using the computer is not a new concept, but transferring testing to the Internet is more recent (Barak & English, 2002). An internet-based assessment could have the advantage of helping the client feel less judged because there is no physical presence, but still allowing the therapist to tailor questions that are particular to the client(s).

Computer assessments could be translated into assessments used to gather information from a client starting Internet-based Family Therapy. An assessment package
for on-line clients could include electronic versions of the following forms: demographics, presenting concerns, previous history of therapy, family supports and issues, educational and vocational issues, family pictures, and inventories such as the Beck Depression Inventory (BDI), Family Assessment Device (FAD), as well as genograms and ecomaps.

*General Internet-based Therapy Issues*

It may be wise for the therapist to have a transition time set aside for going from home life to therapy sessions if they are working out of the home. It is also very important to have solitude and privacy. If a therapist had F2F sessions in the home, they would not allow family members to come into the room during a session and Internet-based Family Therapy sessions should be treated the same. Something that might enhance therapy for the client would be to have homework projects. They could have a personalized webpage with links to homework like completing sentence stems. Homework would be important because, even though a text-based chat session takes an hour of time, it is not an hour’s worth of conversation (Haberstroh, 2002). In text-based chat, there can be long delays between each response because therapist and clients alike go through a process of reading the last statement, thinking about and processing that information, formulating a response, typing the response, and possibly editing or revising that response. Once an assessment is done, then the actual Internet-based Family Therapy begins. There was not a great deal of literature about specific techniques that were well suited for Internet-based therapy.

This next section deals with general issues related to therapy using the Internet and some specific techniques as well. Different types of therapy over telecommunication
lines (telemedicine) have increased in popularity. Maheu and Gordon reported in 2000 that audio teleconferencing was used by 5% of all current behavioral health providers utilizing the Internet for therapy. Family therapists, along with other counselors have taken advantage of multiple media. Some human service professionals began offering individual, family, and group therapy using e-mail as early as the 90s. (Ainsworth, 1999; Colon, 1998; Markowitz, 1999; Osterman, 1997). One study randomly surveyed 150 colleges to see if they were using internet-based therapy services. They found that larger colleges were more likely to use Internet-based counseling services and the larger those services were, the higher the student retention rate was (Waters, 2001).

One of the negative presuppositions associated with telemedicine is that there would be a lack of intimacy and that it would not contribute to worthwhile progress in therapy. According to Rosenfield (2002), therapists said that therapy over the telephone was more intense and that clients reached disclosure and openness more quickly. Derrig-Palumbo and Zeine (2004) reiterated this idea, saying that they had experienced accelerated disclosures to the point that they suggested slowing clients down so that they did not share too much in the first session and then regret it and/or feel embarrassed by their confessions.

In the literature from the past, cost was considered a drawback to telemedicine, but it is not as much of a factor today. Teleconferencing in Europe was said to be half the cost of conventional methods, but in the USA and Canada, the cost was said to be prohibitive (Mielonen, et al., 2002). Today, with internet connections as inexpensive as they are and hardware as cheap as it is, many people are connected to the Internet. For
someone already connected, communicating through a chat style format comes at no extra cost.

*Current Internet-based therapy Techniques*

Collie & Cubranic (2002) discuss the concept of computer supported distance art therapy. Taking advantage of the power and resources that a computer has to offer has the potential to benefit clients greatly. A therapist can observe the client’s artwork and creation in real time (synchronous) and make comments, when appropriate. Internet-based therapy can help clients that otherwise may not have an art therapist in proximity to themselves.

It has been suggested that when doing group work through means of a teleconference, the facilitator can assist by preparing fact sheets in a question/answer format describing how groups are run (Rosenfield, 2002). This same idea would work for a group that uses videoconferencing. The facilitator could simply e-mail the fact sheet – or even a list of topics for the next session – prior to the group. Chat programs now often have the ability to send files through the interface during the chat session whether it be text, audio, or video chat (e.g. If you are videoconferencing with someone and want to send them a picture or word file, you can simply drag and drop the file into the chat window and it will be sent to them).

Regardless of the medium, there are certain issues that are important for any Internet-based therapy. Mallen, Vogel and Rochlen (2005) have several techniques for working with clients on-line. A therapist should discuss the limitations of confidentiality through the medium. Until jurisdiction and scope-of-practice issues are clear, they recommend that therapists only practice within states that they hold a license. If the
therapist plans to save the transcripts of a text-chat or e-mail based session, the client(s) should be informed in a manner similar to the way they would with videotaping. The therapist should keep in mind that saved transcripts could be used by a lawyer who could quote text out of context during a trial without the therapist being there. The therapist should not do Internet-based therapy without knowledge of, and experience with, the technology.

Mallen, et al. (2005) also suggest checking with clients to see if empathy is coming through in a text-based chat. In order to communicate empathy, a therapist should (a) type emotional reactions, (b) use emoticons (emotion icons) and (c) describe nonverbal reactions. In a response to Mallen, et al., Casper and Berger (2005) also mentioned that there is a need for feedback loops, possibly by using questionnaires or direct questions during the on-line session.

Sanchez-Page (2005) states that studying all forms of distance therapy as a whole (i.e. video, text-chat, e-mail, telephone, etc.) loses important nuances. These authors said that there is a need for separate studies. Childress and Asamen (1998) report that video and audio forms of communication will be the next generation of on-line contact. Similarly, one of the “most promising avenues for on-line counseling involve(s) videoconferencing” (Mallen, Vogel & Rochlen, 2005, p. 796).

*Videoconferencing Therapy*

Videoconferencing, in and of itself, may be considered a technique of Internet-based Family Therapy. There are, of course, advantages and disadvantages to this method. The main drawback has been related to issues of power, speed, and availability. In 2002, Mielonen, et al. wrote that the average client – and even the average therapist –
is not going to have a computer with the power to show quality video, but with rapid advancement in technology and hardware costs lowering, video conferencing capabilities are becoming much more prevalent.

Videoconferencing might easily lend itself to a specific theoretical orientation such as Bowenian family therapy. One of the theories that would be easily integrated is trans-generational. It would be easy to use a genogram program to have the family share their genogram. Families could work on the genogram between sessions.

It was noticeable in the literature that MFT theories were not discussed in relation to Internet-based therapy. Cognitive-behavioral was mentioned most often as a viable option. Derrig-Palumbo (2002) states that their research found that the most popular theories for Internet-based therapy are Solution Focused Therapy, CBT and Client Centered Therapy. The lack of discussion specifically related to MFT theories was disheartening and a dialogue about it needs to ensue. Because of the lack of research, one of the specific research questions addressed in this study is related to what theories were mentioned as working well with Internet-based therapy.

Videoconferencing has been used for many purposes in therapy: for families with emotionally disturbed children, teenagers with seizure disorders, psychiatric patients, and for conducting neuropsychological assessments (Zipper, Broghton, & Behar, 2000; Hufford, Glueckauf, & Webb, 1999; Dongier, Tempier, Lalinec-Michaud, & Meunier, 1986; and Schopp, Johnston, & Merrell, 2000). Videoconferencing is less common though, because access is not as available, but it is more dynamic (Zack, 2004). Given the current state of Internet-based Family Therapy, this study will focus on text-based communication.
Therapy Websites

There are several types of on-line practices (Jencius & Sager, 2001). One of the most common websites is a page related to someone’s individual practice. These are often static webpages. Another common type of page is the referral agent’s website where you would go to find a therapist (e.g. www.counseling.com, www.800therapist.com, www.metanoia.org, www.therapistlocator.net). There are also collected practices that may have multiple therapists, each with one specialty (e.g. www.helphorizon.com). Derrig-Palumbo & Zeine (2004) said that active websites (more than just a static page with a bio) could be cost prohibitive – even with a few therapists working together. In order to be useful and well maintained, a site must have full time people that work on programs, deal with viruses and other issues. With development, security, and maintenance a website can cost up to a million dollars. Jencius & Sager (2001) say that in order to keep the cost manageable (regarding web development), it helps to have a larger group practice.

Derrig-Palumbo & Zeine (2004) reviewed mytherapynet.com as a more therapy friendly site. Many therapy websites were actually developed by business people without a solid psychology background while therapists conceived mytherapynet.com. The site is like a building that rents space to businesses – individual private practices. Site owners simply charge 25% of whatever the therapist makes, which is basically the overhead. The attractive part about the pay set up is that the client must pay before the session starts, and it is all done out of pocket (of course, the client can later get reimbursed by a third party payer if they choose). Payment ahead of time eliminates some potential problems for the therapist. Mytherapynet.com suggests $1.60 per minute for services, but the therapists
can decide any payment for themselves. Clients can choose 15, 25, and 50 minute sessions, and at the end of the time allotted, the session automatically terminates giving the client the option to pay more for a longer session. This selected and paid for session time keeps the therapist from going five to ten minutes over without getting paid for it. The therapist does have the option to extend the session for free if he or she wishes to do so. Every other week, the therapist receives a check for services in the mail. A therapist can have an account on this website and simply use it as a means of dealing with payment if they wish, even if all they conducted were F2F sessions. The client can choose a session by phone, chat, video, or in the therapist’s office, depending on the therapist’s preferences. Another option is for the therapist to have his or her clients pay ahead of time through the website and then have the client come into the office. This would be a way to make bookkeeping issues (i.e. payment methods and calendar) simplified.

Not only does Internet-based therapy have benefits for therapists, but it can also provide clients with more detailed information about their therapist and therapy. One study (Palmiter & Renjilian, 2003) found the essential information that consumers want to see on a therapy website: the professional’s degree or licensure information, hours of availability, a list of the therapies offered, a list of problems treated, years of experience, insurances accepted, educational background, fee scale, emergency procedures, a description of policies, and general information on therapy. Also, it is important to have a resumé, and links to self-help resources.

Guidelines for Internet-based Family Therapy

A number of articles reported on the importance of having guidelines for doing therapy over the Internet. The following discussion will highlight what is currently
proposed in the literature, much of which was brought about because of ethical concerns. Through this current research study, it is anticipated that additional guidelines may be revealed and new information will be added.

Negretti & Wieling (2001) discuss some important issues that should be addressed before becoming an Internet-based therapist. One should become familiar with the technology before using it in therapy. If a technical difficulty occurs during the session, the therapist should at least have resources available or on-call to assist. Something not so obvious would be the need to know common acronyms used in the instant messaging (IM) community (e.g. BTW means, ‘by the way’; see http://www.aim.com/acronyms.adp?aolp=). If e-mail is the major means of communication, it is important to discuss confidentiality and the lack of security that e-mail provides. The therapist needs to communicate potential risks, ethical concerns and boundary issues with clients before beginning therapy. It is important for the therapist to reflect on boundaries ahead of time. Will the therapist feel comfortable with clients being able to call their cell phone any time of the day or night? Should the client expect that when they e-mail their therapist, there will be an immediate reply? A guideline more related to phone therapy is being aware of caller ID and *69 (last call return). Therapists can have their numbers blocked to deal with these privacy issues. It has also been suggested that a cordless phone not be used because other devices (such as the neighbor’s baby monitor) can pick up the conversation.

When setting up a website, there are some general established guidelines. A program [an interface or a website] needs to be robust and work well with different browsers (e.g. Chrome, Safari, Firefox, Internet Explorer, etc.). When a website is
developed for a research study – one where people would go to take a survey for example – it should be accurate, intuitive, quick, and slightly boring (Montgomery & Ritchie, 2002). These suggestions work well for a therapy website as well. Derrig-Palumbo & Zeine (2004) suggested that if a therapist used mytherapynet.com and also wanted to create their own website, it would be wise to have a static page with a bio, services offered, and a link to mytherapynet.com. In addition, disclaimers are very important (Finn & Banach, 2002). The therapist needs to make the client(s) fully aware of the limitations of the medium being used as well as the normal disclaimers one would have on an intake form. Disclaimers can also be listed on a personal website.

When using video conferencing as the means of therapy, there are several specific guidelines related to non-verbal technology that have been proposed. It is better to wear light colored clothing, look at the camera when speaking, greet the viewers and tell them what will happen during the session – just like during a regular ‘in office’ session (Mielonen, et al., 2002). The sound and motion of the video must be perfectly synchronized (Zipper, et al., 2000). It is best if the therapist has a room specifically designed and used for videoconferencing, sound quality needs to be high, the picture needs to be clear, and the therapist should have a document camera or virtual whiteboard for sharing (Mielonen, et al., 2002).

Rosenfield (2002) elucidates that silence on the phone should not last longer than seven seconds. Therapists can also specifically talk about what silence feels like or what it is about with the client. The therapist should also pay attention to his/her accent and vocal tone to make the client comfortable because it is more pronounced on the phone.
Rosenfield suggested that supervision for telephone therapy should (at least in part) take place over the phone so that the nuances or issues for that medium can be addressed. This idea takes the principle of isomorphism into account. The same would be true for Internet-based therapy. If the therapist uses instant messaging or video chat in therapy, then the supervision should include the respective method. This principle will likely work the same for research, so as part of the current research methods, text chat was used as a way to communicate with interviewees. This created a more immersive experience and helped the researcher discover aspects of the process that might not have been noticed otherwise.

Regardless of the medium used, the therapist needs to establish a protective environment and a safe climate (Cummings & Bonk, 2002). Internet-based therapists cannot rely on having a certain color carpet, a nice couch, or soothing decorations, etc. It is important to pay attention to the words being used and consciously work at making their clients feel comfortable.

Since few research studies have been completed, most suggestions or guidelines are speculation at this point. There are theories about what will work for Internet-based Family Therapy, but nothing empirically tested. Authors in the field have offered their conjecture. Mallen, Vogel, Rochlen and Day (2005) report that Internet-based therapy would be better for people already functioning at higher levels. These authors do not recommend this venue for serious substance abusers, psychotic, or actively suicidal clients (Mallen, Vogel & Rochlen, 2005). Internet-based therapy may be appropriate for short-term treatments, self-help interventions, and cognitive-behavioral therapies (Mallen & Vogel, 2005). Internet-based therapy may also prepare clients for F2F therapy later on.
in the process (Caspar & Berger, 2005). On the other hand, internet text-based chat therapy may not be appropriate for clients that have English as a second language because their reading and typing skills may be more limited (Mallen, Vogel & Rochlen, 2005).

Some research has indicated that clients are more accepting of the on-line medium than the therapists that do Internet-based therapy. Mallen, Vogel and Rochlen (2005) say that consumers place a higher value on mental health web pages than clinicians do. They also found that clients were consistently more satisfied with Internet-based therapy than therapists. Caspar and Berger (2005) suggest that since therapists are used to traditional therapy, it is easy to avoid learning new methods of service delivery. They say that doing so could keep a subset of clients from getting services since they will never go to an office.

Advantages

It usually only takes about 15 minutes of discussion with a therapist for them to understand the usefulness of Internet-based therapy (Derrig-Palumbo, personal communication, February 4, 2005). In this section, the advantages will be reviewed as discussed in the literature. First, there will be a discussion of the advantages of using computers for enhancing therapy, then a discussion related to the use of the Internet as a medium for therapy.

One of the more obvious advantages of telepsychiatry is that it can bring services to people living in remote areas that did not have service before, saving time and travel costs and allowing quick access to an expert if needed (Finn & Banach, 2002; Mielonen, et al., 2002; and Rosenfield, 2002). With the use of the computer there is a change in the
power relationship in therapy. Especially for on-line, the territory is shared, it is more accessible, and privacy is increased (Cowan, 2002; Rosenfield, 2002). Because of this shift in power differential, clients may be less apt to be dependent on the therapist (Mallen, Vogel, Rochlen & Day, 2005). In an office the territory is the therapist’s and a power differential is evident. This concept is important to consider as it relates to one’s particular theory of therapy because in some theories, a power differential is desired, while in others (e.g. post-modern types of therapy), power equality is preferred. So dependent upon their theoretical stance, some therapists would naturally be more attracted to an Internet-based setting.

Studies show that when people use Internet-based therapy, they take more time to consider their responses. It is possible that in a F2F session, a client may simply respond in a way that they believe the therapist wants, but typing out a response leads some clients to be more reflective about what they wrote. Clients would be more deliberate with what they share (Cummings & Bonk, 2002; Huff & Edwards, 2001).

One of the unique aspects of text-based Internet-based therapy is that the whole session can be recorded verbatim serving as a permanent record (Banach & Bernat, 2000; Negretti & Wieling, 2001). This could be a blessing or a curse and therapists should take this into account so that they do not say anything that they would not want showing up in a court hearing in the future. Derrig-Palumbo and Zeine (2004) indicated that on mytherapynet.com, records are not kept so as to lower liability for the website, but a therapist or a client could always save the session if they desired by copying and pasting the session into a Word document. E-mail or copies of session dialogue can help the
client create a narrative (Jencius & Sager, 2001), which would be of use to someone who comes from a narrative approach.

Similarly, it would not be difficult to record audio or videoconferencing sessions. These can serve as the therapist’s session notes, used for review, and serve as a way to check the progress of therapy. Saving these types of notes could be a way to encourage the client by showing them the progress they made when therapy was terminated.

According to some anecdotal evidence by Derrig-Palumbo and Zeine (2004), people are more open – even knowing a human is on the other end – when typing on a computer. These authors personally had many clients that were not very open during F2F sessions, but who disclosed in much greater depth and detail when having an Internet-based session. Researchers are finding that people are willing to discuss personal and profound issues across networks similar to Internet communication (Barnett, 1983).

Collie and Cubranic (1999) did a study of art therapy on-line and found that clients formed a relationship with the art and described a feeling of safety on-line suggesting that Internet-based therapy is not as sterile as some might think. Alternatively, some clients find Internet-based therapy more comfortable and may disclose more readily, but if disclosing is a problem for them, then this method may not be as effective as F2F (i.e. they are still not facing their fear) (Haberstroh, 2002). In a Family Therapy Magazine article, Scott & Thompson (2009a) indicate that Internet-based Family Therapy tends to have a slower pace, be more focused and cover less ground in a given session. It promotes greater disclosure and clients are more deliberate & intentional about their story and more aware of time.
There are several advantages with Internet-based therapy related to security. Encryption can be used to combat any possible security breaches. Programs can deny access to unintended parties. Mytherapynet.com uses their own server-based chat rooms for therapy sessions, so they do not have to worry about a third-party administrator (e.g. yahoo chat) reading any portion of the session. Further, this company does not save any session transcripts that could later be hacked into by unwanted parties (Derrig-Palumbo & Zeine, 2004). This type of protection along with the use of passwords increases the confidentiality and safety of Internet-based therapy.

Finn and Banach (2002) summarize several of the major advantages of therapy related Internet sites:

- It is available on a twenty-four hour basis from any computer with Internet access, and thus provides a stable source of support in an increasingly mobile society. With proper software, the Internet provides a means to anonymously seek information. It can offer culturally relevant information and services when they may not be available in the local community. The information on the Internet can be readily updated so that it can remain current and relevant (p.134).

The idea of culturally relevant information for clients being accessible translates well into Internet-based therapy because clients can choose a therapist with a similar ethnicity or one that specializes in work with a particular subculture. If a client wants a Christian therapist and does not know of any in the area, they could find one on-line. The same could be said for a client with a handicap, or one of Asian descent being able to find a therapist that has experience working with the respective culture.

Many of the methods used for telemedicine have similar advantages for Internet-based Family Therapy (e.g. clients do not have to travel far distances to receive help, etc.). Rosenfield (2002) lists advantages of telephone therapy (the reader should notice several that have been mentioned by other authors as well). Rosenfield actually submits
that the client holds the power in a telephone therapy session (as opposed to a balance of power) because the client is more likely to hang up a phone than walk out of an office.

There is more privacy. Not only is the client able to keep from walking into a therapist’s office in public, but the expressions and gestures they do are hidden from the therapist. Disclosure feels safer for many people over the phone. A therapist is more accessible and can provide services to more people than when simply doing F2F sessions. Therapy can be more practical and more affordable to clients if it is over the telephone. If a client is ill, disabled, financially restricted, or geographically isolated; they can still have a session over the phone. The client is better able to find a match regarding specialty areas.

*Disadvantages*

Authors have also found plenty of issues that are potential disadvantages with Internet-based therapy. A few of the authors mentioned in the advantages section also had a list of disadvantages, so for the sake of comparison they will be listed first.

There are challenges and risks when using the Internet for therapy. There is not enough empirical research related to effective models of Internet-based therapy (Finn & Banach, 2002; Mielonen, et al., 2002). This is one reason for the importance of the current study. It was anticipated that this research would add to the literature and that it would increase the interest for additional research to give Internet-based therapy a more solid research base from which to work.

There are potential difficulties with an on-line assessment. There is a greater likelihood of crossing cultural boundaries. If a therapist uses an assessment measure on-line, it is important to have norms developed for on-line versions because the method of administration is a variable (Banach & Bernat, 2000). It is also a good idea for the
therapist to have their own picture and a short bio about themselves so potential clients know the ethnicity when they are choosing a therapist (Derrig-Palumbo & Zeine, 2004). Miller and Gergen (1998) theorized that if there is more anonymity in Internet-based therapy, it may increase prejudice and stereotyping (because the therapist is having to make assumptions based on limited information).

The legal and liability standards for Internet-based therapy are unclear, although these issues may vary state to state (Finn & Banach, 2002; Levine, 2000; Negretti & Wieling, 2001). It is also important to know specific laws related to confidentiality and duty to warn issues for any state in which clients reside because sometimes they conflict with other states (Derrig-Palumbo & Zeine, 2004). Additionally, there are security issues and threats to privacy (e.g. hackers) when using the Internet. There is the potential that other parties will harass clients or agencies doing Internet-based therapy (Finn & Banach, 2002; Mielonen, et al., 2002; Negretti & Wieling, 2001). Finn & Banach (2002) mention several more disadvantages: (1) sometimes websites can be misleading or incorrect (2) website start-up and maintenance costs can be high (3) there are many potential clients that do not have access to the Internet (i.e. the digital divide) and (4) there can be a lack of coordination between agencies providing web services.

Many therapists say they would use the computer as a tool in therapy, but feel they lack training, the time for training, or the finances to get the equipment necessary to conduct Internet-based therapy (Aymard, 2000). “Given that many human services professionals have not received direct education in computers within their educational experience, some professionals may have forged a self-image that does not include a feeling of competency with technology” (MacFadden, Maiter & Dumbrill, 2002, p.289).
A lack of experience, training and/or confidence as it relates to technology and Family Therapy does not have to be the norm going forward.

Mielonen, et al. (2002) contrasted strengths of videoconferencing (already discussed) with its weaknesses. Although it can save time and travel costs, time will be wasted if there are major technical difficulties. Even though videoconferencing can connect a client to an expert, there is a dependence on the availability of a communication line, as well as the proper technology on both ends, which replaces the dependency on transportation. A therapist may find that he or she needs to create new routines of operating when using videoconferencing. It may help to consider on-line clients the same as one would F2F clients and not schedule them any differently. Clients should take the same amount of preparation time whether they are F2F or videoconferencing clients. Even though video can be recorded and text can be saved verbatim, it may still be helpful to type up a summary after a session for quick reference.

Another disadvantage of Internet-based Family Therapy is that people are largely unaware of telemedicine and Internet-based therapy as an option. Fears and prejudices are two reasons people might shy away from Internet-based therapy. There is also the difficulty of transitioning into using the new method and the new technology causing stress, which may be a deterrent for some. As with any new activity, planning and preparation are required that could be avoided by simply staying with what is familiar.

Another danger of Internet-based Family Therapy is the possibility that a great deal of distance therapy could detract from normal social relationships. It is reported that greater use of Internet-based communication systems is associated with subsequent decline in family communication, smaller size of local social network, increased
loneliness, and increased depression (Kraut, Patterson, Lundmark, Kiesler, Mukhopadhyay, & Scherlis, 1998; Mielonen, et al., 2002; and Waldron, Lavitt, & Kelley, 2000). Therapists should take caution to not neglect F2F relationships and also discuss the issue with Internet-based clients who may be more apt to spend time relating on-line. It is possible that people might expect too much from videoconferencing. They may think of it as a cure-all, when actually, all types of therapy have negative aspects.

With Internet-based Family Therapy there can be confusion related to expectations and the nature of the therapeutic relationship. For instance, if a potential client e-mails a therapist and the therapist responds, the client may assume that this constitutes a therapeutic agreement when that was not the intention of the therapist. The therapist could send a response and simply state in the response that the e-mail was not intended as a means to establish a fiduciary relationship (Negretti & Wieling, 2001).

There are many additional disadvantages and criticisms in the literature related to Internet-based therapy. There is a lack of visual cues and non-verbals when doing text-based therapy over the Internet (Banach and Bernat, 2000; Negretti & Wieling, 2001; Waldron, et al., 2000). Visual contact is not the only line of communication blocked by distance therapy. The normal physical contact associated with a F2F session is not possible (e.g. shaking hands, the sense of smell, etc.) (Mielonen, et al., 2002).

There is also a danger of the client relaying ‘hyper-personal’ information during Internet-based therapy (Waldron, et al., 2000). Most therapists are aware that too much self-disclosure early on can have a negative impact on therapy because the client(s) may feel embarrassed and either become inhibited or terminate therapy prematurely. The
literature indicates (as discussed earlier) that revealing information more quickly is common in Internet-based therapy.

In addition to the possibility for rapid disclosure, there is a greater chance for misunderstanding with Internet-based therapy. With limited message cues, the tone of messages can be misinterpreted (Waldron, et al., 2000). A genuine concern and one that needs attention is the risk of a misdiagnosis because of relying on limited information (Shapiro & Schulman, 1996). Any client can make up false information, but with an Internet-based client, it is possible that a person could steal a credit card and use it for identifying information. They could actually be a different gender, ethnicity, and even live in a different state than what they have led the therapist to believe. Additionally, if for instance, therapy is occurring through e-mail, a message by the therapist could be misinterpreted and the client would have time to mull over the information until they can respond and get a response letting them know the true meaning of the message – given the asynchronous nature of e-mail. By the time the issue gets resolved, some emotional damage could have occurred. At least with chat style communication (typing, audio, or video) there can be an immediate response, but it is also possible that the misinterpreted information will not be discussed and resentment can grow. One would hope that this danger is not as elevated for the therapist, but it remains important that the therapist keep their feelings in check and address information that they may have misread. It is also commensurate for the therapist to warn clients ahead of time about the likelihood of this phenomenon and to create a dialogue that makes it easier for both parties to broach the subject if they suspect anything (Waldron, et al., 2000).
Another possible disadvantage of Internet-based Family Therapy relates to the ability to process. One dissertation studied process and outcome efficacy of Internet-based therapy (Bogardus Groble, 2002). One hundred and twenty three undergraduates went through three personal growth sessions. Some used Internet-based therapy while others used F2F interaction. The Working Alliance Inventory was used along with an Outcome Satisfaction Questionnaire developed by the researcher. Also, the Meyers Briggs Type Indicator and the C.I.T.E. Learning Styles Inventory were used to gather information. Researchers found that males reported greater process ability in the F2F condition, which did not support one of the study hypotheses. There were no significant results found related to age, ethnicity, introversion/extroversion, or research condition (Bogardus Groble, 2002).

Many of the disadvantages regarding Internet-based Family Therapy relate to the difficulty of communicating without the benefit of non-verbals. The potential for technology failure is another important concern. The connection to clients and families is an important factor in the Family Therapy process and any hindrance to that connection is a legitimate concern.

Ethical Issues

It appears from the literature that the biggest concern related to Internet-based therapy is ethics. There are many areas of concern such as identity of the client/therapist, cross-border/state lines, HIPAA compliance, informed consent, billing policies, treatment of minors, security and confidentiality (Derrig-Palumbo, 2009; “Ethical and legal matters,” 2009). The American Counseling Association (ACA, 2005) has published a set of ethical standards that includes standards for Internet-based counseling/therapy. These
standards cover privacy information, informational notices, client waivers, records of electronic communications, electronic transfer of client information, the appropriateness of on-line counseling, counseling plans, continuing coverage, boundaries of competence, and minor or incompetent clients. According to some, there are many ethical and legal issues that have yet to be addressed by professional codes of ethics and the courts (Finn & Banach, 2002). As mentioned in Chapter I, AAMFT (2012) updated their code of ethics to include Internet-based family therapy. The AAMFT website also has several articles related to Internet-based Family Therapy ethics. To help with some level of uniformity, it is suggested that a national certification for on-line counseling be created (Haberstroh, 2002). The AAMFT provides Ethics Fact Sheets, some which address technology issues, such as “Therapy by E-Mail” and “Confidentiality in the Electronic Age.” Derrig-Palumbo (personal communication, February 4, 2005) said that the greatest misconception about Internet-based Family Therapy is that the fundamental rules of therapy are not used when practicing over the Internet. She said the issues surrounding standards of care, ethical and legal responsibilities and confidentiality remain the same for either in-person or Internet-based Family Therapy.

All the way back in 1985, Sampson and Loesch proposed an additional curricular requirement for Council for Accreditation of Counseling and Related Educational Program (CACREP) schools:

Computers: Includes understanding the relationships among computer technology and counseling and human development services. Emphasis is placed on applications in counseling and human development services, computer literacy, and related issues such as the roles of technology in the professions, ethical concerns and the implementation and management of systems. (1985, p.32)
The CACREP standards renewed in 2009 have no specific references to computer, internet, on-line or world wide web. Under the Professional Identity section, there is a line that says, “Evidence exists of the use and infusion of technology in program delivery and technology’s impact on the counseling profession.” (p. 10).

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFT) published their latest accreditation standards in November of 2005. These standards give no specific mention to anything related to technology or the Internet.

Finn & Banach (2002) list some of the ethical and legal issues related to Internet-based Family Therapy:

- The services were novel and untested.
- There was unclear jurisdiction.
- There was a question of whether it was equivalent to F2F therapy (i.e. no empirical research).
- The duty to warn and to provide emergency services was potentially more difficult.
- The privacy and security of on-line transactions needed to be present.
- It was important to be cognizant of when a fiduciary relationship was established in the therapist’s mind and the mind of the client(s).
- Internet-based assessments might not be adequate
- How should fees be structured?

Meier (2000) mentions several risks for Internet-based Family Therapy groups.

- The facilitator needs to verify people’s identities.
- Responding to emergencies can be an issue.
• Group members may be at risk for decreasing the F2F contacts in their lives.
• Besides hackers and spammers, there will be the normal confidentiality issues with a group setting.
• Without being face to face, group members may be more likely to divulge private information about others.
• Messages in a chat can be copied and forwarded to non-group members.

Most of these risks were true for both individual and family therapy.

Boundaries are an issue with Internet-based therapy. The therapist has to decide what is allowable for out-of-session contact (Negretti & Wieling, 2001). A therapist might choose to see a client in person, but might also need to decide if he or she will give out an e-mail address, an instant messenger account name, a pager or cell phone number. If an e-mail address is given, it would be best to have a separate e-mail account dedicated to clients so that they can be separate from personal e-mail. The therapist also needs to decide how many on-line clients to have at one time (i.e. the ratio of F2F clients to Internet-based clients).

According to Levine (2000), there were several factors affecting ethical concerns related to on-line human services. First, over the last decade, many more human service providers have increased their use of computer technology, which has increased ethical issues. Second, although ethical issues have increased with more internet usage, the laws have not caught up with the technology for issues related to privacy rights and electronic information transmission, retrieval and storage. Third, the growth in managed care has made it become the predominant method of financing and delivering health care, bringing more parties and issues such as transfer of data. Fourth, there has been a growth in the
Health Data Organizations operating under the government, private, and non-profit organizations (designed to improve health care). Fifth, electronic workplace surveillance started occurring (employers search the computer files, e-mail, voice mail, etc.). Finally, there has been a growth in “Telehealth,” which includes Internet-based therapy.

Levine (2000) also created a framework for analyzing ethical dilemmas related to electronic information technology. The framework is structured in the acronym INTERNET: Identify the people and guiding ethical principals involved along with the institutional policies and current relevant legislation (it is important to identify discrepancies between any of these as well), find out what the Needs are of the people involved from a holistic perspective, determine the Terms of understanding between the parties, Elucidate the conflict, Educate the parties involved, and Empower the people to discuss their rights, Reconcile the principals and values to create a plan, clarify the Necessity for resolution of conflict, Evaluate the outcomes of the conflict, and reflect upon how the conflict was Terminated. This framework could help as a decision-making tree when a therapist is dealing with an ethical dilemma.

Haberstroh (2002) provides a helpful summary of the ethical guidelines:

The guidelines state that counselors: (a) review pertinent laws and ethical codes at the state and national level, (b) inform on-line clients about security procedures and potential hazards, (c) inform clients about record keeping practices, (d) ensure that the verification of identities, (e) take extra care to ensure confidentiality of electronic documents, (f) provide links to certification and licensure bodies in the field, (g) have a counselor on-call in each client’s respective locale, (h) inform clients of issues which may not be appropriate for on-line counseling, typically the more extreme and traumatic issues, (i) explain scheduling issues such as when e-mails will be read, time zone issues and delays caused by technological failure, and (j) teach and inform clients to deal with the lack of visual and nonverbal cues (Bloom, 1998; NBCC, 1998). (p. 51)
Specific Ethical Issues

There are several ethical issues that will be discussed in this section. Some of them will seem familiar because they are issues for F2F therapy, but they may have a special connotation as related to Internet-based therapy. Others are uniquely internet matters. For the most part, the literature in this review does not specifically address Internet-based Family Therapy ethics issues (yet another reason showing the need for more research in this area). Breaches in ethical conduct can lead to discipline by licensing boards and even possible job loss (Banach & Bernat, 2000).

Fiduciary relationship

A therapist must ensure that there is a clear understanding of the type of relationship being formed (if there is one being formed at all) with potential on-line clients. If a therapist answers a consumer’s e-mail they should assume that it constitutes a fiduciary relationship (Finn & Banach, 2002).

With Internet services, there may be an implicit assumption on the part of consumers that a fiduciary relationship has been established on the basis of an e-mail transmission. A fiduciary relationship is one in which a professional owes the highest duty towards a client or consumer by virtue of the trust that is conferred…Although a answer to an e-mail transmitted in question may not be regarded as solidification of a fiduciary relationship by a practitioner, a consumer may regard it otherwise (Banach & Bernat, 2000, p.162).

It is important to be specific and have clearly marked boundaries. There should be no question in the mind of the therapist or the client regarding the relationship. If that type of relationship is not intended, the practitioner should clearly state so. A disclaimer regarding this issue would be wise on a therapists website. The question at hand is, “When does a client become a client?” The therapist needs to answer that question clearly for him or herself as well as for the client.
Another concern is related to the manner in which the therapist charges for therapy (Jencius & Sager, 2001). If it is by e-mail, will it be a fee-per-question? If it is a chat style interface, will it be per minute or per hour? Each therapist must decide their method and they can inquire on-line and with other therapists as to what the standard practice is concerning Internet-based therapy fees. The fee structure should be clearly posted on the therapists website and a clear contract must be used (Finn & Banach, 2002).

As part of best practices, therapists have a duty to provide appropriate referrals, a duty to provide appropriate assessments, and a duty to receive appropriate supervision (Banach & Bernat, 2000, p.155).

**Disclaimers and credentials**

Just as therapists would inform F2F clients of particulars related to therapy in an office, there are items that must be addressed with potential clients prior to Internet-based therapy. Some of these items may be a practical matter while others are more serious in nature. A therapist could have a disclaimer on his or her website or they could have a disclaimer sent as an e-mail attachment to clients.

The therapist needs to explain the possibility of a technology failure (i.e. power outages, Internet disconnections, etc.). There also needs to be an explanation for the possibility of misunderstandings because of the lack of nonverbal cues. Even with video conferencing, nonverbal communication can be hard to perceive (Banach & Bernat, 2000; Jencius & Sager, 2001). It is recommended that the therapist encourages clients to voice any issues that they are having because of possible misunderstandings, just as the therapist should let clients know that they will not always understand properly and will
try to clarify as often as possible. Along with a disclaimer, a therapist should post credentials and areas of expertise on their website. Links to certifications bodies and licensure boards are also helpful. Along with areas of expertise, each therapist should state the limitations in their services (Finn & Banach, 2002).

Confidentiality

Confidentiality is probably the ethical issue of most concern. At first glance, it may appear that Internet-based therapy risks confidentiality more than F2F therapy. However, if the proper precautions are taken, Internet-based therapy can be as safe, if not safer than F2F therapy. There are HIPAA compliant modes of communication (using at least 128 bit encryption) for websites such hushmail.com (encrypted e-mail) and gotomeeting.com (encrypted web conferencing) (Anthony, 2011; Nagel, 2011).

Finn and Banach (2002) repeat that therapists need to establish procedures that protect confidentiality. E-mails to and from clients should be treated the same as other client documentation. Passwords should be used along with properly secured backup computer files. Encryption software is available and should be used with on-line communications. If the therapist saves any part of the files, clients need to be informed of how long these files will be kept. Mytherapynet.com does not save any information from sessions (Derrig-Palumbo & Zeine, 2004), but the therapist has the ability to copy and save any part of a chat session.

E-mail can be dangerous because the message can be intercepted or simply forwarded and end up in the wrong place (Banach & Bernat, 2000). It is helpful if the therapy takes place over a secure server that is not in the public domain (such as yahoo chat). If a client is part of an abusive relationship, it is important to inform that client of
the possibility of the abuser finding the e-mails or other evidence of therapy and help
them take the proper precautions to keep that from happening. Baltimore (2000) suggests
that encryption software should be standard in all Internet-based therapy as a way to
protect confidentiality.

There are effective methods for securing local and on-line data. Anyone can walk
into a computer store and purchase a device that recognizes thumbprints as a security
measure for computer files. Of course, there are always ways to get to information if
someone had the wherewithal and the motives. People worry about a lack of security
because lines can be tapped, etc. (Negretti & Wieling 2001). At a minimum, it would be
following best practices to use existing security measures for Internet-based therapy.
There are e-mail clients and chat services that use 128-bit encryption, which is the
HIPAA standard for electronic media.

Jencius & Sager (2001) say that encryption is “arguably greater protection than
what we afford our paper records” (p.296) because if a file gets lost or stolen, only a
person with the proper key would be able to read the contents. Haberstroh (2002) writes,
“I would argue that it would be immeasurably easier to eavesdrop on a face-to-face
counseling session or to break into a counselor’s file cabinet and retrieve his or her
records” than to intercept and decode encrypted information on-line (p. 199). With these
issues in mind, Finn & Banach (2002) also suggests caution in referring clients to on-line
sites and self-help groups.

Protection is especially critical when dealing with victims of domestic violence.
The client should be made aware that they should not store any information related to the
therapy on a computer or as a hard copy so that the offender does not discover the material and create a dangerous situation for the client (Finn & Banach, 2002).

Informed Consent

Just as in F2F sessions, informed consent needs to be obtained, especially if any information is to be forwarded to a third party. There should be a clear explanation of the difference between on-line and F2F therapy – acknowledging that Internet-based therapy is currently untested (Finn & Banach, 2002). It is the therapist’s responsibility to inform the clients of any risks involved in Internet-based therapy (Banach & Bernat, 2000).

It is suggested that the therapist have the client(s) print, hand sign, and mail or fax a hardcopy of the informed consent. It would also be considerate to have a resource page for clients with links to physical locations of therapy resources proximal to them. Therapists should also provide links to license and certification boards, give information about security and confidentiality, and use the most sophisticated encryption available (Haberstroh, 2002). Additionally, an explanation about the pace of Internet-based sessions would be helpful: “Clarification about the limited content and slower pace of the session should be included in an informed consent” (Haberstroh, p. 193).

Duty to warn

Another ethical issue that seems to surface in conversations about Internet-based therapy is the ‘duty to warn’ (Banach & Bernat, 2000). This has become a major concern ever since the prominent case, ‘Tarasoff vs. Board of Regents of the University of California.’ The duty to warn basically states that if a client threatens to kill or harm self or another individual, the therapist must warn the intended victim. This could be come an
issue with Internet-based Family Therapy because the therapist may have a more difficult
time finding contact information for intended victims or other pertinent parties.

Not every state has the same laws regarding duty to warn and, in fact, some states
prohibit contact with authorities or other concerned parties because of confidentiality
laws. The therapist should know the duty to warn laws in their own state as well as any
states or countries of clients they see on-line (Finn & Banach, 2002). Derrig-Palumbo &
Zeine (2004) say that therapy should occur as if the client is coming to the therapist’s
state and the therapist should therefore follow the laws of the state in which they, the
therapist, reside. One suggestion Derrig-Palumbo & Zeine made was that if an on-line
client threatened harm to someone in another state, the therapist could contact their local
police and explain the situation to them and have them contact the person or the police in
that state. If the therapist’s state imposes the duty to warn, they are liable for not
contacting the person directly. This issue alone may be enough to keep some people from
doing Internet-based therapy. At the very least, therapists could simply restrict their
Internet-based therapy to clients that live in the same state. Therapists must simply have
some way to verify that they actually live in the same state (Banach & Bernat, 2000).
Therapists should acquire legal advice before doing therapy across state lines (Finn &
Banach, 2002). Credit card verification may work for this, but even with this method,
there is no guarantee that the client did not steal a credit card and is posing as someone
else. Ultimately, ‘Potentially dangerous’ clients (to self or others) should be seen in
person instead of on-line (Finn & Banach, 2002).

Slavich (2003) researched to find out some basic information about Internet-based
therapy services, and found that many therapists’ views of interstate practice did not
match up with governing bodies. It was pointed out that the issue of interstate therapy is still ambiguous. The one interesting finding that stood out as related to governing bodies was that the National Association of Social Workers (NASW) considers it illegal for social workers to practice outside of their jurisdiction (Slavich, 2003). Slavich (2003) points out that many Internet-based therapists have clients sign a waiver stating that the therapy will be governed by the home state of the therapist, but that this may not actually hold up in court.

**Emergency services**

Practitioners should discuss procedures to be used if a client wants to contact the therapist while they are not on-line. The therapist should give an emergency number where they can be reached or emergency contact information for services that are proximal to the client (Finn & Banach, 2002; Jencius & Sager, 2001). It is important to be able to locate local services for the client (Banach & Bernat, 2000) even if it is not for emergency situations. Therapists need to verify the client’s identity and contact information and they need to be proficient at locating local resources for clients (Finn & Banach, 2002), because they have a duty to provide emergency medical treatment (Banach & Bernat, 2000).

**Inappropriate relationships**

Therapists have a duty to avoid inappropriate relationships (Banach & Bernat, 2000). Negretti and Wieling (2001) point out that boundary violations are often related to sexual issues. It is just as much a concern for Internet-based therapy, and some might consider it even more of a danger because of the culture of many on-line interactions. The same discretion used in F2F therapy is needed during on-line sessions. The therapist
should avoid any type of sexual relationships with Internet-based clients (Finn & Banach, 2002).

Efficacy

Even though efficacy is one of the major concerns, “there is much myth and unfounded speculation surrounding [this] issue” (Derrig-Palumbo, 2009, p. 25). Derrig-Palumbo says that efficacy “should be gauged more on how it may improve access to mental health services, rather than focusing on whether treatments work when used online” (p.25). Although Haug (2009) claims that less than half of e-therapists followed accepted ethical practices and some gave no licensing information, Kazal & Conner (2009) say that many of the liability fears, like malpractice issues, have not been realized. They assert that “time has proven this to be theoretical and not reality” (p. 20). Zack (2008) concludes that even with issues like jurisdiction, licensure, confidentiality, etc., the efforts of Internet-based therapists to provide a needed service to a segment of the population not currently being served by F2F therapy is worthwhile. It is the hope that the current study will help therapists begin to understand how therapists handle issues such as no-shows, emergencies and the like. It is also hoped that the current study will spur more research to find out how these issue can best be addressed.

According to Derrig-Palumbo (2009), Internet-based therapy is not a theory, method or approach – rather, it is a delivery system. She posits that the efficacy should be gauged more on how it may improve access rather than if treatments work when used online. She also states that the efficacy with respect to improving access is undeniable.

Some have approached the efficacy of Internet-based therapy by looking at other therapies with less direct therapist contact and then drawn conclusions based on that
evidence. For instance, there is evidence that Bibliotherapy may be as effective as F2F individual therapy for panic disorder (Klein, Richards & Austin, 2006). There is evidence of symptomatic improvements with the use of on-line self-help groups (Skinner & Latchford, 2006). Others go as far as to say that “there is now robust evidence on the basis of randomized controlled studies that cognitive therapy through the Internet is feasible and effective” (Van Diest, et. al., 2007, p. 116). Skinner & Latchford say that psychological treatment over the Internet has been shown to be effective for panic disorder, PTSD & eating disorders. “Online therapy can be an effective mechanism to interact with your clients” (“Ethical and legal matters,” 2009, p. 44). There was a study done by Van Diest, et. al. (2007), which found that 67% of the participants dealing with sexual dysfunction judged their sexual function to be much improved with internet treatment.

Even with some claiming evidence of efficacy, that evidence is still sparse and questionable. Even if the reader takes the research at face value, these studies still do not specifically focus on family therapy over the Internet, suggesting that there is plenty of room for more research in this area.

Haberstroh Study

The empirical research that most relates to the current research study is Haberstroh (2002). This research sought to create a grounded theory of relating therapeutically on the Internet. Six therapists, seven clients, and two supervisors participated in five chat-based sessions and were then interviewed. There were seven client participants (six female, one male; 24-53 years old). The study examined how
effective and how appropriate Internet-based therapy was for participants (Haberstroh, 2002).

Haberstroh (2002) discusses how text chat therapy sessions could be powerful because it effectively compels the client to journal. Journaling can be a preventive measure and invites contemplation into deeper levels of meaning for therapeutic issues (Lantz, 1997; Pennebaker, Colder, & Sharp, 1990; and Riordan & White, 1996).

Some important concepts that Haberstroh (2002) finds related to Internet-based therapy were as follows: Technical and interpersonal barriers; relating in a nonverbal environment, which can facilitate or inhibit disclosure; the delay between responses, which can lead to unfocused or reflective conversation, the convenience of on-line counseling; facilitating the on-line counseling relationship, with a need to do a lot of reflecting and summarizing; and difficulty in completing an assessment.

Online counseling was beneficial to clients when: they were comfortable with technology, the software and hardware systems were stable, they focused on personal growth, their counselor-participant responded reflectively, both the counselor and client-participant waited during intervals in the dialogue, they appreciated the convenience of on-line counseling, the nonverbal environment provided safety, and interacting from home was comfortable, but not distracting (Haberstroh, 2002). These findings from Haberstroh are compared to the findings from the current study in Chapter V.

Summary

In this chapter, the following topics were reviewed: general technology and psychology issues, technology and education, technology and therapy, web therapy issues, Internet-based therapy techniques, therapy websites, guidelines for Internet-based
therapy, advantages, disadvantages, and ethical issues. At this time, the empirical research is limited and as discussed in this chapter, has focused primarily on potential ethical issues. This review confirmed the value of the current qualitative study as adding an important contribution to the knowledge base in an exploratory fashion. This study also added the additional specific dimension of Internet-based Family Therapy.

Internet-based therapy is in the infancy stage of development. It is generally agreed “research into this area is scant and sorely needed” (Negretti & Wieling, 2001, p.290). The Internet is a new medium for doing research. Although recruiting participants on the Internet can be less expensive, less time consuming and may yield a more representative sample than more traditional means of research, there is little empirically grounded research that proves its ethical and professional viability.

The reader should now have an idea about the current state of Internet-based Family Therapy. After the review of the literature and the review of Haberstroh’s 2002 study, the reader should have a context for the current study. The purpose of this qualitative research was to add to the knowledge base about the field of Internet-based Family Therapy research.

This study adds to the literature because there is so little research on Internet-based Family Therapy. It is a qualitative, phenomenological study interviewing actual Internet-based Family Therapists with experience in this field and gaining insight about their perspective on the phenomenon.
CHAPTER III
QUALITATIVE RESEARCH

As discussed in the literature review, there is a need for more empirical research on Internet-based therapy. The following qualitative study was designed to further knowledge of Internet-based Family Therapy. The overarching question asked: “How do therapists experience the phenomenon of Internet-based Family Therapy?” The sub-questions were: 1. How is Internet-based Family Therapy defined by therapists claiming to do it? 2. What are the presenting issues for Internet-based Family Therapy going forward?

Methodological Framework

The framework for the study was Phenomenology. The foundational question in this framework is “What is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?” (Patton, 2002, p.104). Phenomenology has been used so frequently that it can be referred to as an inquiry paradigm, a philosophy, a qualitative tradition, a social science analytical perspective and orientation, or a research methods framework (Creswell, 1998; Denizen & Lincoln, 2000; Harper, 2000; Husserl, 1967; Lincoln, 1990; Moustakas, 1994; Patton, 2002; and Schultz; 1967, 1970).

As Patton (2002) expresses, phenomenology focuses on how humans make sense of experiences and bring them into consciousness on an individual and shared level of
meaning. The goal for this study is to describe how the phenomenon is perceived, described, felt about, judged, remembered, made sense of, and discussed. This required in-depth interviews with people that had actually conducted family therapy over the Internet. A phenomenon studied can be an emotion, a program, a method, a relationship, or many other experiences (Patton, 2002). Internet-based Family Therapy is a method of conducting therapy. The questions asked to participants were about their experience of using this method of service delivery.

Heuristic Inquiry

Heuristic inquiry, from the perspective of Moustakas (1981, 1990 & 1994) was used for this study. A brief overview follows to describe Heuristic Inquiry.

Immersion

The researcher experienced the phenomenon of on-line text communication (the method being studied) by conducting interviews through an instant messaging format and through e-mailing questions and receiving e-mail responses. It was anticipated that doing text-based interviews would give a greater immersion and insight into this mode of communication.

Incubation

Incubation for the current study required the researcher to make sure not to rush the experience. The researcher reviewed the collected data as well as notes from personal experience multiple times, but took care to withdraw from the material in between for periods to let his subconscious process it well.
Illumination

The researcher organized ideas started in the previous stage, forming structures and patterns with the purpose of deepening understanding. It is during this stage that he began to develop and discover themes in a more solid sense. The researcher foresaw practical categories starting to emerge here.

Explication

During this stage, the researcher reflected back on the primary and sub-questions and additionally reviewed the questions from each round of data collection with the intention of gaining a fresh perspective on the data.

Creative synthesis

The researcher looked at each part of the study to find connections between them. This part of the process became clearer as it materialized. The initial information blended with newer information to illustrate the phenomenon of Internet-based Family Therapy.

In this process the researcher was focused on what his experience was as a researcher and how the therapists experienced Internet-based therapy. The goal was to understand how they saw this delivery method of therapy affecting their interaction and how it affected presenting problems. The researcher also wanted to know if they felt that Internet-based Family Therapy revealed anything to them about the relationships in the family that ordinarily do not come to light. In order for the researcher to immerse himself more into on-line communication (as discussed below), he used instant messaging and e-mail communication as the means to communicate with the participants. In this way, he experienced interaction the same way that therapists and clients do when they do Internet-based therapy.
Research Design

During and after the collection of data, there was an iterative process of reviewing and synthesizing the material in order to discover new material to add to the literature. The design was based off of Moustakas’ (1981, 1990 & 1994) model described above. Each segment of the data collection is discussed below.

Data collection

There were three main segments of data collection. The first was an open-ended interview protocol. The second was e-mail follow-up questions based upon the results of the interview (with a potential second round of e-mail if needed). The third segment was based on the researcher journaling his particular experience throughout the study.

The participants were contacted through the site that they used for doing Internet-based therapy. The researcher e-mailed a letter requesting their participation (see appendix A). The letter was e-mailed to the website administration and then forwarded to the potential participants. Therapists that accepted the invitation were sent the informed consent (see appendix B).

A semi-structured interview protocol (see appendix C) was developed for the first round of data collection. The interview protocol was developed based on information gathered from the literature review in Chapter II including results of the Haberstroh (2002) study as well as the pre-study information. The interview protocol started off asking for demographic information. The interview protocol had six open-ended questions. The questions asked the participants to explain their experience of Internet-based Family Therapy and to share other information from their perspective such as some of their concerns regarding the medium, which theories they use, contraindications, and
advantages & disadvantages of on-line therapy. The goal of this first stage was to attain approximately five participants with the belief that this would generate sufficient data to get a solid base of information and develop questions for the email(s) to follow. The researcher reserved the option to do more than one round of follow-up questions by e-mail if needed. Participants were told at the outset of the study of the two portions of the study (i.e. the interview and follow-up e-mail[s]). A table illustrating the data collection can be found in appendix E.

The interviews took place as a text-chat (which is also known as instant messaging) using the same interface that therapists use with their clients during therapy sessions. According to Moustakas (1990), the conversational interview is most clearly consistent with the rhythm and flow of heuristic exploration and search for meaning. A conversational interview encourages expression, elucidation, and disclosure of personal experience. The researcher considered including other methods such as voice chat or video conferencing, but believes that this would have brought in too many variables, would be beyond the scope of this study, and would create a lack of focus. Most Internet-based therapy today occurs using a text-based method. Most of the questions were typed out ahead of time, but the author reserved the option, during the interview, to ask follow-up questions that were of merit based on the direction of each interview. This flexibility is one of the benefits of doing qualitative work. The process was as follows: The researcher copied and pasted a pre-written question, the participant answered the question, then the researcher asked a follow-up question based on the new information when appropriate. The process was repeated for each question from the interview protocol. Each participant was asked for 50 minutes of time for the one-on-one
interviews. This seemed like a reasonable amount of time because many therapists were used to that time period for therapy sessions. If the questions were answered adequately before that time ended, the session would end early. The transcripts from the chat-based interviews were copied and pasted into a Word document. Each participant was identified by his or her e-mail address and name. Confidentiality was maintained in the same manner as in studies that incorporate face-to-face interviews. Transcripts, notes, and personal documents, such as journal entries, were organized in such a way as to tell the story of each participant (Moustakas, 1990).

Once the first level of analysis (i.e. the initial interview) had taken place, participants were e-mailed follow-up questions synthesized from the data collected from the interview. The e-mail follow-ups were mostly for clarification of the new data collected in the interviews. Participants were also then e-mailed the preliminary results of the data analysis and asked to respond as a means of member checking. The member checking fit the study because in Heuristics, research participants are viewed as co-researchers.

Another significant part of the data collection, given the model used, was gleaned from the researcher’s personal experience. Throughout the process the researcher journaled is experiences (described later in this chapter). Not only did he review the data that was collected multiple times, but as he went along, he reviewed his journal entries along with the data from other participants. This journaling process was done in order to reflect the contemplation, depth & immersion of the researcher. For the heuristic researcher, an immersion into the data takes place (Moustakas, 1990).
In Heuristic Inquiry, the researcher is open in searching into a problem. This can lead to finding more literature, other people, institutions and more data collection. It permits a shift in methods to allow for the richest collection of information. The goal is to dynamically pursue knowledge. The data is collected and documented with descriptions, dialogue, metaphors, analogies and anything that gives a clear, accurate, and full revelation of experience (Douglass & Moustakas, 1985).

Data analysis

The transcription from four sources (Pre-study material, Semi-structured interview, follow-up e-mails, and the researcher’s journaling) was used to analyze the data. The results from the interviews were analyzed using the constant comparative method. After analyzing this information, new questions were created for the e-mail follow-up. Once responses to the e-mail follow-up were received, the interview transcripts and e-mail responses were studied, and topics started to come into focus. Finally, the resulting findings were e-mailed back to the participants for their reflections as a means of member checking. This new data was used, once again, to analyze the data.

Once general topics started to come into focus, a coding system was developed. The codes were used to categorize sections of transcripts that epitomized the particular code (exemplars). The researcher used Microsoft Excel™ as a means of sorting and analyzing data. Any software program is, at its base, a tool to store, organize, analyze & present information that used to be done without the aid of a computer. The researcher used a method incorporating Excel introduced by Swallow, Newton & Lottum (2003) that is a “simple and rigorous method to manage and display qualitative data using widely available computer software, which removes the need to acquire and learn more
complicated, dedicated software” (p. 610). The researcher input key ideas (from reading interview transcripts, follow-up e-mail responses and the researcher's reflections on the process and phenomenon) into Excel. There was one idea put in each cell, almost like a digital version of note cards, giving the researcher the ability to rearrange and organize the information with a great deal of flexibility. Each cell was expanded enough to fit the paragraph it contained. Each Excel file is a workbook with multiple pages. The first page was used as a clearinghouse for all key ideas. Once this page was complete, it was studied to find similarities within all responses. After these similarities were found, all subsequent pages were titled by topic or idea - one topic per page. This was the process of coding the information in order to categorize and organize it.

After the pages were named based on the differing ideas, each unit of information on the front page was copied and pasted onto the corresponding topic page. Once this was accomplished, the transcripts, e-mails and journal entries were studied again (as part of the recursive process) to find additional ideas that fit well within the codes that had since been established. This process occurred several times until the researcher felt that the essence of the data was encapsulated well within the Excel pages. The process started after the first round of data collection (using the interview transcripts, the researcher's journal entries from the interviews and pre-study material) and it was repeated after the follow-up e-mail responses were obtained. The codes were developed in differing stages throughout the data collection process. From the intensive analysis of data, the codes were developed into themes. The information was then distilled into a manageable form that could be used to write Chapter IV. Within each page of the Excel file, quotes from
transcripts or journal entries that summarized each particular theme were used as exemplars.

The Heuristic researcher immerses him- or herself into the data in order to have a full understanding of the individual participant and balance that with a full understanding of the phenomenon as a whole (Moustakas, 1990). Heuristics emphasizes a depth of experience on the part of the researcher. In addition to the information gathered from study participants, the unique experience of the researcher informs the study and its outcome. The researcher of this study had multiple experiences to draw from (e.g. as a therapist, a user of on-line interaction methods and as a researcher of the literature) and explored each one as part of the data analysis. Again, the steps in analyzing the data were from Heuristics, based on Moustakas’ work. Those steps included immersion, incubation, illumination, explication, and creative synthesis and were executed in the manner described above using Excel as a tool for working with the data. The synthesis of the researcher’s experience along with the information gathered from the data sources helped the researcher speak to the “meaning, structure, and essence of the lived experience for this phenomenon” (Patton, 2002, p. 104) for people doing family therapy over the Internet.

*Report of Project Piloting*

Before the study began, a pilot study was done. There were three parts to this pilot study: (1) an exploratory Internet-based Family Therapy session, (2) a telephone interview with the CEO of an Internet-based therapy website, and (3) a run-through of steps 1-4 of the data collection process used for the current study.
The first part of the pilot study was a mock Internet-based Family Therapy session. For this, the researcher recruited members of a family (a mother, father, and daughter). The researcher acted as the therapist. The mock therapy session took place in a text-based chat program. The therapist was in one house, the mother and father were in another house on separate computers, and the daughter was in a third house. The therapist was actually three hours away from the family members during this mock session. Portions of the transcript were used in Chapter II of the current study to show examples of how family therapy could occur over this medium. The goal of this portion of the pilot study was to get a better understanding of how Internet-based Family Therapy might function. There was an additional advantage because the researcher gained valuable experience acting as a therapist doing (mock) Internet-based Family Therapy.

The second part of the pilot study was the telephone interview with an Internet-based therapy company CEO. She herself is a family therapist and has conducted workshops on Internet-based Family Therapy at the national AAMFT conference. The researcher inquired about the state of Internet-based Family Therapy (e.g. Are there actually people doing Internet-based Family Therapy? What does Internet-based Family Therapy look like – do you have all the family members participating? Do those therapists do Internet-based therapy exclusively or a combination of on-line and face-to-face therapy? etc.) as well as recommendations for the research process.

The third portion of the pilot study was the process of going through the steps of data collection and transcription used in the current study with an Internet-based Family Therapist that was not one of the participants in the larger study. The goal was to get a very general idea about how the process would go during the actual study. The researcher
journaled by reflecting and writing about his experience of the process during each portion of the pilot project.

The researcher not only journaled about the process of Internet-based therapy during the mock session, but also about the process of on-line communication based on the interactions with participants during the initial interviews and during the second portion of data collection (i.e. the e-mail follow-up questions). The researcher tried to write a rich of a description for journaling by reflecting on the touch, sight, smell and sound of the process. Considering this interaction was remote communication, some of the reflection focused on the lack of normal senses that occur within a therapy session.

The researcher also used findings from Haberstroh (2002) to compare with the data from the current study as a way to further analyze the data. Once themes had been generated, the Haberstroh findings were reviewed for similarities and differences with the data from the current study.

The dissertation that is described at the end of Chapter II (Haberstroh, 2002) was used as a catalyst for the research in this study. Haberstroh’s study used students as participants that played the part of on-line therapists, clients, and supervisors. The methodology of the Haberstroh study was different from the current study, but the subject matter was very similar. The current study used therapists that actually did Internet-based Family Therapy as part of their job. In the data analysis, the author compared the results from Haberstroh’s research with the data being generated from the current study. The goal was to see if this research validated or reflected any of the Haberstroh findings.
**Website**

The participants were associated with a particular therapy website. The website is described here to help the reader understand the process of using the Internet for therapy and how the therapists operate. This website has professionals from many mental health related fields (e.g. marriage and family therapy, psychology, counseling, etc.). The best metaphor for how the website works is that of a building being rented. In a physical building, each independent, private practice therapist rents out an office space. The owner of the building is not their employer. In similar fashion, the website being used does not employ each therapist, but simply rents the virtual web space and maintains the overhead of running a website. The therapist pays a percentage of their income from the website for this purpose. Of note, the website’s policy is that they do not save any transcripts or records of therapy. If the therapist wants his or her records saved, he or she must save it locally.

The pool from which the participant base came is a website that specializes in Internet-based therapy. The website was founded by professional therapists. All of the therapists that use the site must verify that they are licensed in the particular field from which they come (e.g. MFT, Counseling, Psychiatry). The therapists could be located anywhere in the United States and other countries.

The services on this website include Internet-based therapy via text chat, audio chat and/or video chat. It can also serve as a referral base for in-person and telephone therapy. There is an “E-mediate” Care service for clients looking for immediate assistance (similar to a telephone hotline). Therapists on the website can also offer life coaching, career coaching, and mediation.
When a client signs up to use the service, he or she input their credit card information. This is a means for payment and a way for the site to verify their physical address (important for therapists wanting to have clients only within their state and to find emergency care in the town or city of the client). The client can choose a therapist from their specified criteria (e.g. male/female, specific specialty, ethnicity, etc.) and are then directed to the therapist’s calendar to see what days and times are available. Then once a session is booked, an e-mail is sent to the client to remind them of their appointment. If the client logs on a few minutes early for their session, they are directed to a virtual waiting room.

Participants

The researcher used purposive sampling to secure a minimum of five key participants for the interviewing phase. The therapists that were asked to participate in this research protocol fit the following criteria. Being that this was a qualitative, phenomenological study, the participants were seen as experts. They were licensed as marriage and family therapists or had a different license but indicated in their bio on the website that they had a specialty in either couple or family therapy. Since the aim of these criteria was to reach the broadest possible participant base, participants had a broad range of ages, ethnicities, locations and other demographics. All participants had a good enough grasp of the technology involved that they were able to conduct on-line sessions. Each participant had done work with families on-line. The therapy with a particular family could have been exclusively on-line or as a mixture of on-line and face-to-face. The therapist could also do Internet-based therapy exclusively for their practice or have a
mixture of on-line and face-to-face clients. Demographic information such as age, ethnicity, sex and technology background/comfort level was gathered.

Knowing the iterative nature of the research process, the researcher reserved the right to declare a need for more participants. On the other hand, if there were more than five potential willing participants at the outset of the study and a need for exclusion criteria, the researcher first excluded people that were not clinical members of AAMFT, then determined the level of experience in Internet-based therapy (i.e. how many families have they seen via on-line methods and/or how many sessions have they had via on-line means?).

In essence, the participants are the study. The experiences and perspectives of the participants is the subject being examined. Along with the experience of the researcher, the insights that the participants shared is what generated content for the study, findings & conclusions.

*Credibility*

The constant comparative method (Glaser & Strauss, 1967) was used to analyze the data. The purpose of this study was not to generate theory or necessarily achieve saturation. The purpose was simply to learn about the phenomenon. Initially, codes were generated for general themes and then the transcripts were studied to put sections of text into categories, looking for exemplars. Two experts reviewed the results. For this study, expert was defined as a person with training in the field of marriage and family therapy or research design. This expert check was part of the triangulation process designed to increase validity.
Member checking was also used as a means of triangulation. Once results were attained, the results of the study were shared with the participants to get feedback from them to assess whether the information accurately portrayed their experience of the phenomenon. If there were any questions about answers, clarification was given.

An element of Heuristics was added to this study because it focused on the experience of the researcher as well as the experience of the participants. Being aware that the researcher cannot escape his subjective nature, he wants to make it overt. He also felt that it was important to balance emic and etic perspectives (Patton, 2002) during analysis to give the participants a voice (emic) and to see the phenomenon from an outside perspective (etic) for a general view of what happens. In one sense, the researcher has an etic perspective because he does not do Internet-based Family Therapy. He has a base of knowledge from studying literature on the subject. Also, he is unsure about the idea of Internet-based Family Therapy (i.e. He does not know if he would want to do Internet-based Family Therapy). This increased the credibility of the study because the ambivalence served as a neutral screen for results.

In another sense, the researcher had somewhat of an emic perspective. He is in the field of family therapy and the participants were family therapists as well. The design of the study promoted the emic perspective by the researcher using the very medium being studied (i.e. e-mail and instant messaging/text chat).

Trustworthiness

There were member checks to ensure accuracy in the analysis. The researcher increased transferability through the use of thick, rich description and exemplar quotes from the transcripts. Further, he had an outside auditor (with expertise in qualitative
research) check the work to make sure that the methods were appropriate. The data were
made available for confirmability on a CD and included the transcripts (on Word and
Excel documents). Any identifying information was altered to protect anonymity. During
the study, the identifying information was kept in a folder that was password protected
and encrypted with 128 bit encryption. The credibility and trustworthiness of Heuristic
research is considered intrinsic:

The validity of heuristic research is inherent, insofar as it pursues the truth, to the
extent that it is conducted through authentic self-processes, and to the degree that
after repeated examinations of the data, the same essences are revealed with the
same degree of plausibility. (Douglass & Moustakas, 1985, p. 44)

Ethical Considerations

To insure ethical procedures, the established IRB process was followed. Each
participant was given an informed consent. Confidentiality was of utmost importance. All
data was kept in a secure location and was only shown to others that were involved in the
study and mentioned in the informed consent (i.e. chair members, outside auditor). All
identifying information was altered. All identifying data was destroyed after the
completion of the study.

Summary

This chapter was an explanation of a qualitative study designed to further the
knowledge base of Internet-based Family Therapy. The overarching question asks: “How
do therapists experience the phenomenon of Internet-based Family Therapy?” The sub-
questions were: 1. How is Internet-based Family Therapy defined by therapists claiming
to do it? 2. What are the presenting issues for Internet-based Family Therapy going
forward? This research was conducted over the Internet. Internet research has the
advantage of a diverse population pool and it reduces time delay between communications compared to mail and reduces paper waste.

The framework for the study was Phenomenology; specifically, heuristic inquiry, which includes five major phases: immersion, incubation, illumination, explication, and creative synthesis. The research design started with an open-ended interview protocol and then employed follow-up e-mails for clarification. The participants had all done Internet-based Family Therapy and were properly qualified.

The constant comparative method (Glaser & Strauss, 1967) was used to analyze the data. Two experts reviewed the results. Member checking was also used as a means of triangulation.
CHAPTER IV

RESULTS

The aim of this qualitative, heuristic and phenomenological study was to better understand the phenomenon of Internet-based Family Therapy from the perspective of the Internet-based Family Therapist. The overarching question asks: “How do therapists experience the phenomenon of Internet-based Family Therapy?” The sub-questions ask: 1. How is Internet-based Family Therapy defined by therapists claiming to do it? 2. What are the presenting issues for Internet-based Family Therapy going forward?

The methodology discussed in Chapter III drove this research study. With Phenomenology and Heuristic Inquiry guiding the work, the researcher sought to discover the meaning, structure and essence of the lived experience (Patton, 2002) of the participants. The process of data collection and data analysis were often overlapping (i.e. the Constant Comparative method explained in Chapter III) as the researcher was going through the steps of Immersion, Incubation, Illumination, Explication and Creative Synthesis. The literature review informed the questions for the on-line text-based interviews. The researcher continually re-analyzed the information as more data came, whether because another interview had been completed, the different participants each sent their responses for e-mail follow-ups or from the data generated through the researcher’s journaling about the experience had using the on-line medium for the interviews.
Participants

Since this is a qualitative study, the author acknowledges that the data collected is not ‘generalizable’ in the sense that quantitative data is, but it nonetheless can give some insight into the phenomenon of Internet-based Family Therapy and help us to understand where to focus future research. With this in mind, here is some demographic information about the participants from this study. There were two males and three females. Participant ages were 27, 44, 45, 51 and 62 years old. All claimed to do Marriage and Family Therapy and have had experience with couples and/or families in the on-line setting. Most were Masters level and two had a Ph.D. One participant claimed to be “Credentialed in Distance Counseling.” Another taught MFT for over 10 years and was on a state licensing board. Experience level doing therapy ranged from 4 to 30 years.

This study was Heuristic in nature and data gathering included the researcher’s personal experience using the on-line medium for communication during the study. Some insights gathered from the experience are shared throughout Chapter IV.

Five participants were recruited in this study that through various Internet-based therapy websites. This section will give an overview of each participant. A summary chart is provided below to help differentiate each participant. The participant description section is ordered loosely on experience and qualification levels.
Table 1

Participant Information

<table>
<thead>
<tr>
<th></th>
<th>Edith</th>
<th>Justin</th>
<th>Steven</th>
<th>Natalie</th>
<th>Andrea</th>
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<td>45</td>
<td>44</td>
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<td>Caucasian</td>
<td>Caucasian, Russian background</td>
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<td>MA Counseling Psychology</td>
<td>MS Criminal Justice &amp; MSW, PhD in Counseling Psychology</td>
<td>MA in Psych</td>
<td>Counseling Psychology</td>
</tr>
<tr>
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<td>Nationally Certified Counselor, Licensed Mental Health Counselor, Credentialed in Distance Counseling</td>
<td>Social Work</td>
<td>MFT</td>
<td>LPC</td>
</tr>
<tr>
<td>yrs of experience</td>
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<td>30</td>
<td>15+</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

*ethnicity was as stated by participants

Edith

Edith (51) is a Caucasian female with a Ph.D. in Human Development and Family Studies with a specialization in MFT. She has an LMFT, taught MFT for over a decade,
chaired a program for several years, was on a State MFT Board for several years and was the President of a state AAMFT division. She came across as experienced and confident in the work she does. Being on a state board, she dealt with ethical issues related to Internet-based Family Therapy. This experience gave her worthwhile insight into the topic. She made the distinction that Internet-based therapy can be done with quality and we need to protect the reputation of the profession by doing Internet-based therapy well.

Her experience is that Internet-based Family Therapy is best done with one or two people. She mostly uses Skype video with the couple sitting in front of the same computer. Presenting problems tend to be relational, couples in crisis, individuals with depression or mission teams dealing with dysfunctional system dynamics.

She sees confidentiality (a secure connection) and inability to clearly read nonverbals as two issues for Internet-based therapy. She noted the importance of looking into the camera, so the client(s) feel that you are looking at them.

She believes that any MFT/systems theories should work well on-line, although experiential therapy may be harder. She primarily uses Narrative and Multigenerational Therapy.

She considers Internet-based therapy as a second choice when F2F is not possible. She likes that it gives people the opportunity to have therapy when they otherwise would not be able to get it. She has found that cases involving high emotion are the hardest.

Her style of communication during the interview was mostly in short paragraphs with a few short answers. She said she likes to use humor in F2F, but it gets dampened on-line.
Justin

Justin (62) is a male with a psychology Masters and has been doing therapy for 30 years. He is credentialed in “Distance Counseling.” He has seen on-line clients from ‘all over.’ He has used video and highly recommends it, particularly for things like role play and couple interaction. His experience is almost always working with the family regarding family issues, parenting and communication. He has also done text chat, but considers it more like psychoeducation, but still part of the therapy process. He considers client education level and client motivation to be important factors in Internet-based therapy.

His communication style is to keep responses brief and send them often, so that the client knows he is there and responding. During the interview, he would use “… as a way to let me know that he was still composing a thought.

He uses cognitive approaches, Experiential & Structural Therapy and Systems Theory. He says that there is no need to change his theoretical perspective from F2F to Internet-based Family Therapy. Just like in F2F, he sees individuals for things like anxiety, depression, trauma; couples and families. He considers Internet-based therapy to be not as effective, but convenient for families that would otherwise have difficulty getting therapy (rural, small communities, etc.). He noted that lack of body language and tone of voice are missing with chat-based therapy. This lack of non-verbals is because of the ‘virtual’ nature of Internet-based work. He also believes that the flexibility with on-line work outweighs the limitations.
Steven

Steven (45) is a white male with an MS in Criminal Justice and an MSW as well as a PhD in Counseling Psychology. He is also the director of an agency. He has done couples work on-line, but said that often only one half of the relationship is involved in therapy. He pointed out that having both individuals involved gives a much more accurate picture of the issues. He has worked with clients from many different countries all over the world. Steven was the most verbose and opinionated expert interviewed.

He said that until recently, a majority of sessions took place over text chat, making it hard to see non-verbals and more difficult to engage. He does a mixture of chat and voice (phone) sessions now. He noted that the writing skills of clients makes a difference in the quality of sessions.

As will be discussed in the theme sections, many of the concerns Steven had seemed to be born out of the structure of the particular site he uses. These concerns related to the client’s true identity, a sense of needing to pander to the clients in order to have positive reviews, and not knowing when the session would cut off. The issues he brought up did not seem to match up with the other experts interviewed that use different websites for their work. This difference brought in a richer pool of data that helped give a broader understanding of concerns related to Internet-based Family Therapy.

Steven uses CBT, Solution Focused and crisis theory in his on-line work. He also brought up another issue that may have related to the parameters of the website he uses. Many of the other participants said that F2F is preferred. Steven suggested that Internet-based therapy maybe shouldn’t even be considered therapy (although he does submit that Internet-based therapy is helpful to clients and “meeting an unmet need”).
Lastly, he told a very interesting story about a client that lived in another country that threatened suicide and explains the lengths he went to in order to do due diligence and make sure she was taken care of.

*Natalie*

Natalie (44) is a Caucasian female with a Masters in Psychology and a License in Marriage and Family Therapy. She has been in the field for seven years and has been doing Internet-based Family Therapy for four years. Her on-line experience includes normal sessions as well as crisis intervention. She said that 10-15% of her practice is on-line. She uses text chat, video conferencing and phone. Mainly, she uses text chat. The interview started off a little shaky because she was in a different time zone and the reseracher had calculated the time difference incorrectly (an experience an on-line therapist would need to watch out for). Her communication style tended to be short bits of information, but volleyed several different bits at a time.

Natalie sees on-line work as convenient for the therapist and time saving for clients. She has children and finds that having Internet-based therapy as part of her work gives her desired flexibility to balance work and family. She also says that some clients suffer from anxiety or shame and Internet-based therapy is a medium to help them overcome those issues. She recognizes F2F as a better alternative, given that body language and emotions can be missed and content can be misinterpreted.

Cognitive, Solution Focused and short-term therapies are what she tends to use on-line. She does not see them being different on-line compared to F2F. She points out that delusional, paranoid or borderline clients would be difficult on-line because they need strong boundaries set, and it would be hard on-line.
She personally has not had any technical difficulties doing therapy on-line. In her opinion, Internet-based therapy is flexible and convenient to be able to work from home with small kids. She said it is “somewhat outside the box, but can extend help to many people who won’t come in the office for face to face work.”

Andrea

The final participant, Andrea (27), is a white female with an LPC. She was the youngest participant and the one that most recently started working as a therapist. She has been doing therapy for four years and Internet-based therapy for over a year. For this interview, we were going to use the expert’s therapy website for the chat interface, but they were having technical difficulties (something she said was rare), so we switched over to Skype. She noted at one point that she was under the weather. This is something the researcher would not have realized had she not pointed it out.

Andrea uses text chat and video for therapy and does initial consultations through e-mail. She likes that when couples are doing text based therapy, they can see what each other says (i.e. harder to ignore) and posits that they are less inhibited in their own home. She says seeing them in the home setting (through video) gives more insight into their daily life.

Something very interesting that Andrea said is that she is not doing any F2F because she just moved with her husband to a new area that is saturated with therapists, so she has been working exclusively online. She illustrates that the on-line world opens up a new market for therapists if they have geographical constraints for finding work. She said that most of the clients do video, but the rest are either text or phone. She pointed out, like other experts, that video is much more widely available and better quality today.
Andrea pointed out, like the others, that privacy, missing signs of potential self-harm, and the additional barriers or distance between clients are some of the major concerns with Internet-based therapy. She has also noticed less accountability with on-line clients. She emphasized the need to make sure the therapist has the client’s real name and address in case there is a duty to warn issue.

General Systems Theory and Structural Family Therapy are what most seem to influence her on-line work. Lastly, much like the other participants, she agreed that there are times when F2F is better for clients, but that it may not be the right choice for everyone.

**Overview of Core Themes**

There were several themes that surfaced from the interviews and e-mail exchanges with participants. Themes came about in different ways. Some of them were a fairly direct result of questions asked in the interview protocol. For example, one question asked about the advantages and disadvantages of doing Internet-based therapy. A theme that arose directly from this question had to do with a comparison between Internet-based therapy and F2F.

Other themes and ideas were not so much born out of the research questions or specific interview questions, but rather from commonalities that emerged from each interview. The reader can note one instance in the description of participants, in that, every participant shared the same sentiment: their belief that F2F family therapy is preferred over and considered superior to Internet-based therapy, but that Internet-based therapy is better than a client getting no therapy at all.
Originally, there were twelve topics that came to light. Those topics were as follows: Practical technical issues, Modality, Number of Clients, Comparing on-line to Face to Face, Is it even therapy?, Ethics, Pros, Cons, Technique, Theories, Power & Anonymity and Client types. In studying the data further, the researcher was able to narrow them into five different main topic areas: Practical Issues, Clients, Online vs. F2F, Theories & Technique and Ethics. With these topic areas as a guide, the researcher discovered six different themes. Each of these themes helped answer the question “How do therapists experience the phenomenon of Internet-based Family Therapy?” Those themes are as follows: (1) The sites may be deemed not truly therapeutic, (2) The use of video is highly recommended, (3) More severe clients are contraindicated, (4) F2F is better than Internet-based Family Therapy, however, Internet-based Family Therapy is better than nothing, (5) Theory use on-line is much the same as in F2F, and (6) The main concerns are confidentiality, crossing state lines & harm to self.

There were practical issues that hit upon the surface of Internet-based Family Therapy. How does one realistically do it? The participants gave explanations of different practical technical issues for a therapist. They also explain the different modalities of Internet-based therapy and how they work together (i.e. text chat, voice, video). The contrast of descriptions between the different participants brought to light that not all Internet-based therapy sites are created equally and some are set up in a way that can hinder the therapeutic process. Others are set up to closely mimic the F2F experience as much as possible allowing for fewer obstructions of the therapeutic process. This indicates “the sites may be deemed not truly therapeutic.”
Learning about practical matters, particularly the specific modalities used, the researcher discovered that the participants believed that video-based therapy was the best on-line option. All the participants used multiple modalities, but they each have their drawbacks. It was clear that “the use of video is highly recommended.”

Another major theme was about clients. Who is being served? Also, how does the modality affect the therapist/client relationship? The topic of “clients” addresses the types of clients, and the number of clients in a session. The experts interviewed also shared some thoughts about client power and anonymity. One clear message from the participants was that “more severe clients are contraindicated” for Internet-based Family Therapy.

A fourth theme came from information about on-line vs. F2F family therapy, really getting to the question, “How are they different?” There were statements throughout the interviews comparing the two. The Pros and Cons of Internet-based therapy are shared. Participants also give their opinions on whether or not Internet-based Family Therapy should even be considered therapy. The dominant message with this topic was that “F2F is better than Internet-based Family Therapy, however, Internet-based Family Therapy is better than nothing.”

Going a little deeper, the topic of theories & technique gets at the question, “What drives the process?” The experts give their thoughts on different theories that work well and those that do not in the on-line setting. They also talk about specific techniques they use when doing Internet-based therapy. It was evident from their answers that “theory use on-line is much the same as in F2F” therapy.
Finally, and not surprisingly, ethics were widely discussed in the interviews. This discussion got to the concern of how to do Internet-based Family Therapy safely and legally. There were several different ethical concerns cited, but “the main concerns are confidentiality, crossing state lines & harm to self.”

After reading through the results organized by the aforementioned themes, it is hoped that the reader will have better insight into the phenomenon of Internet-based Family Therapy, have a better sense of how therapists define Internet-based therapy and will be more aware of some of the presenting issues with this modality of therapy.

Before getting into the main content, note that some of the quoted sections of interview may appear disjointed. This is because of the cadence during an interview through the text chat based medium. The researcher intentionally did not edit these inconsistencies because he hoped it would help the reader get a clearer picture of what Internet-based communication is like in practice. During the actual interview, a sequence may have occurred like this: R asks a question, P makes a point about the previous topic, R responds to P’s comment, P responds to the new question, etc. Going back and reading the transcripts after the fact brought to light this disjointed feel that was not really noticed at the time. Punctuation, spelling and grammatical errors are left as-is in the quotes. A few times, certain quotes are repeated in different sections because they relate to multiple themes and it would not do either theme justice to leave out the quote in each case. In those instances, the quotes are simply referenced or a small portion of the quote is used so as to not have too much redundancy.
Core Theme 1: The Sites May Be Deemed Not Truly Therapeutic

In this section, different practical issues are explained. There are several practical technical issues that experts shared, including Site Structure, Technical Failures, Communication with Clients and Room Setup. The Modality is also explained.

Participants had some ideas related to different technical issues an Internet-based Family Therapist needs to be aware of. The structure of the website can have a big impact on the dynamic of the therapeutic alliance. It is important to be aware and make clients aware of potential technical failures that could occur in the middle of a session. The therapist needs to be clear and open with the way that they communicate with the on-line clients. Lastly, this section will touch upon the need to put thought into the room setup for Internet-based Family Therapy.

Site structure

A great deal of thought must go into the choice of a website for doing Internet-based Family Therapy. Some entrepreneurs have already put thought and effort into creating Internet-based therapy sites, but not all are created equal. Something the researcher noted while journaling during the research process is that even as a relatively tech savvy researcher, he had difficulty finding good therapy sites. People not very adept at searching on-line would have difficulty. This spoke to the idea that not only does a therapy site need to be set up a certain way, but if the on-line presence is hard to find, it will not matter how well the site is set up.

Andrea was on a site that had several helpful aspects for the client. Once the client creates an account they have access to the following tabs: Home, Office, Mail, Sessions, Journal Forms, Files, Billing, Calendar, My Info & Help. This helps the client stay on top
of and in control of their appointments and gives them opportunity to work on their issues outside of the therapy session. In journaling, the researcher noted some thoughts about working with documents on-line.

It would be optimal to have secure forms that people can fill out on the therapist's website so that it automatically gets sent to the therapist (no need to print out, scan, resend, etc.). There is technology that allows multiple people to edit a document on-line simultaneously. A secure version of this could be very useful depending on the activity. Alternatively, there are times that a therapist may want to create a document and have it presented to the client (like having them verify that a genogram is correct). (Journal)

Steven shared the need for having quick access to different therapy related documents that he may need to access for a client or family. He maintains an office that he uses for face to face work and tries to keep a strong therapy file in his electronic documents that allows him to quickly send articles, questionnaires, or informational items on the computer. Natalie added some additional thoughts about dealing with paperwork on-line. She handles paperwork the same way it would be done face to face. She said that many forms are now on therapist websites.

Steven was very passionate about the problems on the site that seemed mostly driven by the parameters that were constructed on the site he used.

Steven: most sessions are 45 min to an hour F2F, on-line sessions are at the mercy of the funds supplied…we are literally cutoff when the money is gone. So by the very nature of on-line work…being largely controlled by MONEY that no real time guideline can be enforced…I can't make them talk for an hour when they have paid for 27 minutes

Steven: Some counselors are doing on-line work and charging for blocks of time…that would be more legitimate than the taxicab meter running on [SITE REDACTED] and other sites

R: Yes, I guess how the site is set up may determine many of the issues you bring up.
Steven: Of course we try to address the REAL need… but we would be liars to not acknowledge the very real issue of ratings…and client funds.

R: I've talked with others that use a different site with a different layout. Maybe the site creator needs to take into account the idea that the process can't be driven by ratings.

Steven: Maybe we would feel an hour is REALLY needed, but they can only pay for 12 minutes… do we tell them "I can't help you… ethically you need at least a full hour"… so they would just go to the next one on the list.

Steven: Exactly… however… some weight must be given to the client's perception of how well the person did… but they can rate after 5 min.

Steven: OH, one big issue: WE may only address HALF of what needs to be said, but the caller is cutoff when the money is out… So… we can't finish our train of thought or the needed analysis of something.

Steven: AND we don't know up front how much time a caller has paid for… and it varies by whoever they CHOOSE to call… Someone may get 20 minutes with me and 11 with someone at a higher price.

Steven: Often in mid sentence we are disconnected… so we can't deliver the whole package.

R: I know of one site that is set up more like traditional F2F and they come for their appointment at a specific time and it is 50 minutes (maybe also a 25 min option) and the therapist has the ability to extend the session for free or for more $$.

Steven: That is more appropriate and more clinical in my opinion.

R: Wow, disconnected mid sentence.

Steven: So the sites themselves may be deemed not truly therapeutic.

Steven: I often will send an email inviting them to finish their story and give them some direction… for free, so as to not abandon their needs.

R: [Site Redacted] is the site I'm thinking of. Recently, ironically, the site has been down. They even have a virtual "waiting room" for the client when they hop on-line and are ready & waiting for the therapist.

Steven: that's great… I guess here is an issue… Most sites are not designed by clinical people… and counseling is an add-on…
Steven: So money & profit is the main [sic] focus

There was not much comment from other participants about problems with site structure. That noticeable absence is what made this a prominent theme in the researcher’s mind as he kept reviewing the data. Since they had different setups, there were fewer barriers to the therapy process.

Technical failure

A real concern for doing therapy over the Internet is a technical failure. There are many points of potential failure from each computer, either modem being used, the operating systems, the ISP, the therapist website and website backend, the browser being used (or a chat client like Skype), to the batteries in your keyboard or mouse, etc. The researcher had some thoughts about this in his journaling:

There is the added risk of technology failing – the computer, the Internet connection – a storm, the batteries in my keyboard. Technology continues to improve, but I make sure to eliminate as many potential failures as possible. I use a wired keyboard and mouse when doing the interviews. The way that I save the transcripts is to simply copy and paste the transcript into a Word document. To be extra precautious, I save it in two ways. I have one file that I continually save along the way – adding new interactions as we go. Once the interview is completely over, I’ll go back, highlight the entire conversation and copy & paste into a separate Word file. The worst that is likely to happen is that we actually get cut off in the middle and have to resume the interview later. For a client in an actual session, a break in communication would likely be more jarring. I know that the literature recommends warning clients about this ahead of time. It hits home more now as to why this would be so important to do on the front end. (Journal)

The researcher had an exchange with Andrea about her thoughts on technology failures. A technical failure actually occurred in our interview. We were going to use the interface on her website, but something had crashed, so we needed to switch to Skype. She did explain that there are normally not any problems on her end and gave a little more insight into what Internet-based therapy looks like: “Technical issues make it very
difficult sometimes. My service provider is excellent, but the problem - 97% of the time - is on the client's side.” She also said that the concerns tend to be “just technical savviness problems, wrong internet, no flash player, their computer not updated.”

Justin noted how technical difficulties can impact video-based family therapy in particular:

R: What can you say about reading non-verbals over video vs. face to face?

Justin: video is pretty good…if the connection is good there is little or no time lag; if the connection is slow, then its odd, because of the time lag…you may hear them say something…and then a minute later see their mouth move, and their facial expression...so, that doesn't work so well. Video is very close to face to face IF the connection is good and there is no time lag...

As mentioned in the participant descriptions, Edith had done work with missionaries. The researcher inquired how technical difficulties might be in that setting, because for people doing mission work, there could be even greater concern for getting a clear connection, especially if they are in a third world country. She said, “Yes, that is a problem. It's getting better now, but several years ago, there were delays in the speech. It was doable, but annoying for everyone” (Edith).

There were a couple of comments about what to do in the event of a technical failure during a session.

Technical issues are of some concern...as mentioned, [sic] with video, you need a good fast connection...if there is some kind of disconnection, there needs to be an alternate way of connecting, just to touch base and reschedule. (Justin)

“When the video cuts out, we keep talking. I use the chat when both video and audio lapse” (Edith). The text option comes in handy when audio and video cut out. That way they know someone is still there.
Communication with clients

When communicating with clients, Internet-based Family Therapists need to make sure clients understand the potential for technical failures, know the flow of information works differently with text chat, and also need to make sure to be clear about scheduling issues. Edith ran into scheduling issues dealing with missionaries because of very disparate time zones. She pointed out the need to be flexible with scheduling. “Scheduling can be a challenge when they are in another country. You have to take time zones into consideration. The main thing with Internet-based therapy is an ability to be flexible” (Edith). During the interview with Justin, he warned about the potential for technical failure that the researcher would have otherwise been oblivious to. “…it just started storming here, so hopefully, we won’t get cut off” (Justin). The researcher gathered some insight into how a therapist would need to communicate with a client when Andrea mentioned feeling a little sick during our interview. “Sorry if I'm not more helpful - I'm a little under the weather today” (Andrea). A few lines later, the topic was broadened a little:

R: Just a comment on something you said - Being 'under the weather' - there are several thoughts that gives me. 1. If it were face to face, it may have been reason for cancellation. 2. I couldn't detect from our text conversation that you were under the weather from non-verbals or appearance. 3. Sharing that information could be helpful for me.

Andrea: Good thought! Yes, if it had been a client that would have needed me to invest emotional energy in them, I would have rescheduled, because I know I could not give them the care they deserve - but for more minor illnesses - allergies for example, I have continued to see them and often they don't know. I will probably still do some email sessions this afternoon because I can take my time with them. :)

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It was mentioned earlier that sometimes the transcripts seem disjointed because of the timing and cadence of text chat. The researcher mentioned this to Justin and he had some thoughts to share:

R: Another issue I've found is the timing of responses with text-chat. Can you speak to that?

Justin: there are a few different chat platforms, some better than others; for example, as I am typing here, you should see a little notice above this box that says I am typing…some chat platforms don't have anything like that, and they are the worst, because you don't know what's going on on the other side. The best one I have found is at [Site Redacted] where it is very real time; we can each see what the other person is typing as they type it… I try to keep my responses brief and send often...so they know I' here and responding…the typical therapeutic stance of silence and observation doesn't really work here...:)

R: the prompt letting you know the other person is typing is helpful.

Justin: yes, it is helpful, and kind of important…

One last phenomenon to mention in this section about communication on a practical level is about the flow of the conversation. When interviewing Steven, he and the researcher were discussing one topic. The researcher thought they were done with that topic and asked a new question. Steven continued to add more to the previous topic. About a minute later, the researcher asked, “Did you see my last question?” Steven continued on the previous topic, the researcher gave a prompt, “Interesting” for him to continue on the previous topic. The question the researcher asked was at a time stamp of 10:27:47 and Steven answered the question at 10:31:12. The reader could note that maybe the researcher needed more patience and should not have jumped to a new topic quite yet, and in one sense, that is the point in bringing up this occurrence. With the pace and cadence of text chat conversations, people’s stream of thought gets conveyed differently than through verbal means. Sometimes a therapist or client may need to ask,
“Did you see my last question?” This could be something addressed in the informed consent for on-line clients and families.

To address this issue of a difficult flow in communication in text chat, some therapist participants would give a text-based indication that they were going to say more. The researcher made a comment about this during the interview with Justin.

R: By the way, I noticed you doing something that is a good communication skill with the chat interaction. If you are giving a longer response, you'll add a "..." to let me know you have more to say. That seems helpful.

Some participants went about this by giving multiple short answers in quick succession. Others would type out part of a longer response, and add “…” to the end and send it and proceed to type the rest of the paragraph. This allowed the researcher on the other end to (1) start reading their response so they wouldn’t have to wait as long once the full response was sent and (2) let me know they were still composing more of their answer. The prompt was quite helpful and just another example of something to consider when learning about good on-line communication in the therapy context.

Room setup

In the researcher’s journaling, he addressed the need to be cognizant of the physical room in which the therapist is conducting the Internet-based Family Therapy as well as the equipment being used.

There should be thought put into the room set up. If you're doing video, have a pleasant, professional looking background. Have good lighting. Don't wear a striped shirt that will hurt the eyes of the client. If it's just chat or audio, don't have distractions. Decent quality mic and camera are important. Fortunately, many computers come with adequate hardware for doing Internet video chat. (Journal)

In response to a set of questions in a follow-up e-mail, Steven and Natalie each gave their thoughts on room setup. Natalie asserted, “If the sessions are skyped then the
client will only be able to see the direct view of a therapist.” Steven said, “It is important to be situated away from noisy household items such as TV, stereo, washing machine, etc…when at home.” Natalie also commented, “The room set up can be very flexible. At times I would do sessions out of my office and at times out of my home.”

Core Theme 2: The Use Of Video Is Highly Recommended

With on-line communication, there are multiple modalities that take place. Text chats, e-mail, video, audio only, and other variations and combinations of these forms all occur in different settings, including Internet-based Family Therapy. From doing the literature review and having the interviews with Internet-based Family Therapists, it seems clear that text chat and video are the two most popular modalities for Internet-based therapy. The participants had insights to share about this topic. The different modalities of Internet-based Family Therapy can be Text Chat, Video, or Multiple modalities (i.e. some combination of the two).

During the interview with Justin, we were discussing ‘video vs. text’ and he shared that the most important aspect is the “conveyance of information.”

R: Looking at your previous response, you don't view text chat as actual therapy, so when I asked "what does Internet-based Family Therapy look like" that would only include text chat as a part of the process?

Justin: text chat is part of the process of therapy…or, rather, psychoeducation is part of the process of therapy and that part can take place in chat very easily…

Justin: for example…I might have one or two sessions with a couple about family dynamics in chat, and then go to video sessions

R: I know when I've been video conferencing with my brother, we usually have a chat window open and that adds another depth to the interaction.

Justin: it does, yes; and it can also be distracting. It depends on what you are trying to accomplish. The conveyance of information does not need
anything else but the information…That information can then be built upon in video with examples, expressions, role plays, etc…

Justin: Of course, it doesn't have to happen that way…some family or couple sessions begin right away with video…but, there is still the psychoeducation piece that is important for them in understanding what we are doing, why we are doing it, and where we are going.

One of the researcher’s journal entries makes note about text and video and the state of things today.

One of the things sticking out most to me so far is how quickly technology changes and advances. I tried to speak to this in my first three chapters, but even the very first interview I did gives evidence that in many ways we have already reached a time when video chats are accessible to people and will take precedence over text chat. My goal for the dissertation is that it brings more awareness to the field that there is need to study and learn about the efficacy of Internet-based therapy. I can see that future studies will need to include, if not focus on video conferencing solutions. (Journal)

Text Chat

Some on-line therapists still primarily use text chat for their sessions. The researcher asked Natalie to describe the process of Internet-based Family Therapy. She said that she uses Skype, text chat and at times, phone, though she mainly uses text chat.

As shown in an above quote from Justin, he considers text chat as part of the process of therapy. Sometimes it is used at the introduction for psychoeducation leading into video-based therapy. Sometimes it is the sole means of communication. Steven spoke to the significance of the client’s writing skills in text chat as well as the shift in therapy mediums over time.

One point to make is the writing skills of the [client] becomes very apparent and of course those with strong skills present the most details and the most meaning to those details…Some clients present such a poignant story that you can "feel" the pain…coming thru in their choice of words…Other times, language barriers inhibit their ability to "tell their story" (Steven)
Andrea pointed out a positive related to text chat when she was describing the process of Internet-based Family Therapy. Family members may be more likely to register the thoughts of the other family members because the thoughts are typed out. She said she uses text chat and video and does her initial consultation via email, but rarely email beyond that. “[It is] interesting in text-based mediums because they can "see" what the other person has said…makes it harder for couples or parents & childrens [sic] to talk over each other” (Andrea).

Video

One point that surprised the researcher was the emphasis some experts gave to video. As was pointed out in Chapter II, the literature suggests text chat is the main method used. Also, there is a likelihood of Internet-based therapy shifting more towards video. The statements from participants in this section seem to corroborate this idea, which is how this theme (the importance of video) came about.

There were several insights that were brought to light by Justin related to video chat therapy. He highly recommended it and gave some examples of when it is practical to use certain techniques.

R: In your experience, what does Internet-based Family Therapy look like

Justin: for Internet-based Family Therapy, the use of video is highly recommended, and I have done that often, though sometimes phone. In almost every case so far, family therapy is working with the couple re: family issues, often parenting, but couple communication does come in as well...

R: In my literature research, I found that much of Internet-based therapy happens through text chat. Is that just a matter of the technology catching up (since you say you do video)?

Justin: text chat is much more used, more popular…For therapy, the role playing and interaction with the couple is important, and for that video is needed.
People are I think still a bit shy re; video, and one of the features of on-line counseling is anonymity, which is kind of gone with video..

R: What can you say about reading non-verbals over video vs. face to face?

Justin: video is pretty good…if the connection is good there is little or no time lag; if the connection is slow, then its odd, because of the time lag…you may hear them say something…and then a minute later see their mouth move, and their facial expression…so, that doesn't work so well. Video is very close to face to face IF the connection is good and there is no time lag..

When the researcher asked him about what theories he uses in the on-line setting, he mentioned something else about the importance of the use of video.

Justin: …when it comes to some role playing and implemtation, [sic] then video is more important…

R: So, as far as role playing, that could fit in with Experiential. Am I hearing that right?

Justin: Yes, experiential, which is an important part of structural/systems family therapy…

Finally, he pointed out the importance of video, specifically for couples and family work.

Justin: most of the people who come to on-line counseling [sic] are seeking help for individual issues, anxiety, depression, trauma…relationship advice…the second tier would be people seeking specific couples counseling…the last tier are people seeking family therapy…I think that is still a very new field for on-line services, because, to be effective the video is really part of it…as with couples counseling too…

R: Regarding the family therapy on-line, I've heard examples where maybe a kid is in college and the parents live in another state, but with an on-line chat, they can interact with a therapist. That seems like it would be one of the times it would be 'better than nothing'

Justin: yes, and I've done that with couples, not familes…one patner is in one state, and the other is out of the country…we connect together on skype…
Edith said she mainly uses video chat for Internet-based therapy. In her experience, it has been with the couple both sitting at one computer together (which, again, would make sense in the context of working with missionaries).

Edith: On-line therapy in my experience is best done with one or two people. I have primarily utilized skype in order to see the clients. When working with a marital couple, they both are sitting there together. Most of my experience has been working with one person at a time on skype. The first session as in my face-to-face sessions is an hour and a half and subsequent sessions are one hour in length.

R: When you say Skype, do you mean video chat specifically? Text, Audio or some mixture thereof?

Edith: Video chat.

In Steven’s experience, the ratio is about 60% text chat & 40% audio and/or video chat. Of course, one expert’s anecdotal experience is not meant to generalize to all of Internet-based Family Therapy, but it is interesting that his experience used to be 80% text and that is shrinking as technology improves.

According to Andrea, when one does video chat, he or she has a little insight into the couple’s home life. She also shared some information about the frequency of text vs. video.

Andrea: Well, I think it's interesting how people can be less inhibited meeting a therapist in their own home - so to speak

R: Explain

Andrea: Especially for couples with video therapy, I will see their dogs, their decor, witness them dealing with distractions

Andrea: Gives me more insight into their day-to-day lives.

R: Interesting. I used to do In-Home family therapy. I never thought that some of the benefit - like you just mentioned, may spill over into the on-line setting.
Andrea: :) It can also be a distraction, but more often than not I've found that it allows me to draw something from their environment to discuss.

R: Can you give any examples?

R: (actually, I guess you did - dogs, decor, etc.)

Andrea: Thinking of a discussion with a couple who was discussing how she liked to get notice before friends came over, he was more laid-back and just wanted to go-with-the-flow…she would gesture towards what I assumed was the kitchen when she talked about it...

R: Good example.

R: For you, what has been the ratio of 1. text vs. audio vs. video and 2. F2F vs. online?

Andrea: it's hard to put my finger on it, but she worked from home, and would talk about the paintings on the wall from time to time. I guess it helped contribute to my understanding of her as a orderly, home-focused person.

Andrea: Recently?

R: Sure.

R: p.s. The little indicator that the other person is typing that is usually here in skype seems not to be working. That does add difficulty to the conversation.

Andrea: Right now I am doing no face-to-face - it's a long story, but I followed my husband to school in an area that is saturated with counselors. So I have not been able to get any face-to-face work. Outside of that probably most is my primary email consultation - because I offer that free. Of clients who set up sessions, probably most is video sessions, second is divided between text & phone. Some people simply prefer one medium.

Andrea: Sorry about that, on my end it's working!

R: No trouble. At least it's working for you.

R: What thoughts do you have about text vs. video, so far in my interviews, it seems that video is rapidly becoming the norm, while since the literature is dated, it talks about text being the dominate form.
Andrea: I think that's probably because when this started, video wasn't as good as it is now - now it's almost as good as talking face-to-face

Multiple methods

Participants have alluded to the fact that there is a mixture of different mediums used for Internet-based therapy. Sometimes, they start out with one medium and move to another, such as that mentioned by Justin earlier where he would have one or two sessions with a couple talking about family dynamics via text and then move to video sessions. Other times, they happen simultaneously. The researcher wrote about this concept three separate times from different angles in the journaling process.

There is fluidity between the different modalities. Edith even mentioned a scenario where in one session, it could be possible to be doing video, have the video cut out, move to audio only, then have that cut out and move to text chat (because of technical problems or bandwidth issues). Something else that seems to be materializing is that communication, and therefore therapy over the Internet is not likely to take place over one medium – in one form. I can easily see it being a mixture of text, audio & video in synchronous and asynchronous forms. At least, I can see a video chat taking place with an open text dialogue happening at the same time. Just from personal experience video conferencing with family, this could enhance the conversation and also acts as a back-up when video cuts out – it still allows you to stay connected and gives assurance that the other party is there.

Text Chat vs. Video vs. Audio: They are all taking place. There is no way to get around it. Video may be on the rise, but Text Chat isn’t going away anytime soon, so they are all in need of further study. People may desire to have some clear answer as to the specific percentages of each modality across all family therapist or one particular therapist’s percentages, but it seems a little messier than that. It may depend on the site that they are using as to whether one modality is even offered or what gets emphasized. Future studies may choose to focus on one particular modality, but a finding of this study is that they are all taking place and fit into the puzzle somehow. It may even be erroneous to say that future studies need to isolate each (text vs. audio vs. video) and focus on each individually. That could miss some key ways that they interact or work in chorus with each other. If I look at my relationship with my brother, it occurs F2F, over the phone, over chat, over e-mail, through video conferencing, etc. They all play a part and I typically don’t spend time analyzing how much of each to try and measure the quality of the relationship. They are all parts of the connection. That is just an initial thought and should not be used as a cop out for continued study.
Maybe a good way to say it is that Internet-based therapy includes a conglomeration of Text Chat, Audio and/or Video. This could be true at the level of the Family Therapy Field, for one particular therapist’s experience or even down to the level of one particular client family. Given the above ideas, all forms of Internet-based Family Therapy need further study and none should be ignored or seen as less important. (Journal)

In the literature: practical issues

In this study, participants talked about the impact of clients being comfortable with technology and that the therapy could go more smoothly if the clients were tech savvy. One study looked at how effective Internet-based Family Therapy could be when the clients had experience using technology (Carey, Wade & Wolfe, 2008). Those that had prior regular technology use decreased depression and those that didn’t had more anxiety.

This section of Practical Issues also looked at the different modalities being used (i.e. text & video). There was a study done by Gilkey, Carey & Wade (2009) that looked at video-based therapy. Part of what they found was that the client did better when they accepted the idea of doing therapy through video. Mallen, et al. (2005) also promoted the use and study of videoconferencing as a means of therapy.

Some participants in the current study talked about dealing with technical difficulties and the Gilkey, et al. (2009) article suggests that important factors for success are how ready the client is to address their issues and their patience with technical difficulties.

Core Theme 3: More Severe Clients Are Contraindicated

When collecting and analyzing the data related to clients, there were four main categories that information fell into: client types, the number of clients seen, the power
differential on-line vs. F2F and issues related to anonymity. The participants suggested that many ‘milder’ cases would be fine for on-line work, but that the more extreme cases were best reserved for work in the office setting.

When the experts shared their thoughts about client types, they either talked about clients that should not be seen in the on-line setting (contraindicated) or clients that are good candidates for the medium.

*Contraindicated*

Keep in mind that most of the responses from participants about contraindications are not based off of literature and research, but rather their personal experience and what seems like a bad idea. The researcher asked each participant if there were any populations or presenting problems that they would consider contraindicated for Internet-based therapy. Justin said the clients that were not good candidates for on-line work were “severe mental illness, suicidal, autism...those are a few that I would refer to local community supports” (Justin). Steven stated, “Suicidal issues, Borderline issues needing DBT, dissociative issues, I guess the modality limits the effectiveness of whatever the issue.” Natalie noted, “someone who is paranoid or delusional, someone who would question you because they cant see you face to face in the office.” Also, “someone who is borderline may have difficulty with it.” And finally, “for a therapist working with personality disorders is always good to be able to confront or set strong boundaries if need be and its a little more difficult with those disorders” (Natalie).

Andrea brought up a good point that just because intuition or opinion-based literature considers something counterintuitive, it may not be the case. “[A contraindication would be] suicidal clients according to the literature, but then I wonder
about the long history of suicide hotlines. Seems contradictory for me.” Andrea also suggested play therapy clients or anyone that doesn’t have a “good command of written language,” such as preteens. She mentioned several other contraindications as well:

People who need more monitoring - addicted populations, for example, I would be concerned about accountability. Borderline & bipolar to some degree because they can be more reactive, and you don't want them to misunderstand something you wrote down because they didn't have verbal/visual cues. (Andrea)

Edith said situations that would be difficult on-line include a high level or grief (dealing with the death of a loved one), a high level of anger (some marital situations), deep shame or embarrassment (when revealing sexual abuse), or times of deep remorse (when admitting to an addiction).

Early on, it might not be very easy to assess for severity: “…the demarcation between what is so severe that it can't be dealt with on-line sometimes does not become evident until you've been working [with] them a bit on-line” (Justin). This issue is dealt with more in the Ethics section.

Good candidates

Just as there are clients that should not be seen on-line, there are, according to the participants, some client populations that do seem well suited for on-line work. The researcher asked the participants whom they thought would or do work well.

Most of the people who come to on-line counseling are seeking help for individual issues, anxiety, depression, trauma…relationship advice… specific couples counseling…the more educated the better generally, but not always the case…client motivation is far more important than client education. (Justin)

Andrea brought up that some clients might actually work better on-line than in person:

I can get teenagers to open up to me over email and chat in a way they absolutely will not in person. I specialized in adolescent work when I worked in person, and I can tell you with teenagers it's often easier to use on-line. (Andrea)
Lastly, Steven mentioned that military personnel use Internet-based therapy a lot. However, in the literature review, it was pointed out that active duty military during actual combat may be contraindicated.

**Number of clients**

When the researcher asked the participants about the number of clients they see when doing Internet-based Family Therapy, the general consensus seemed to be one or two people at a time, but not much in the way of whole family units (including children) simultaneously. From the researcher’s work as a Marriage and Family Therapist, this sounds similar to the answer he would give if he was talking about his F2F practice. “On-line therapy in my experience is best done with one or two people” (Edith). “Usually just 2 people…” (Andrea). “In almost every case so far, family therapy is working with the couple re: family issues, often parenting, but couple communication does come in as well…” (Justin). Steven said, “the majority of my calls involve relationship issues.” He sometimes sees both the husband and wife together, sometimes both separately, but often just one side of the relationship. As a marriage and family therapist doing face to face sessions, there are plenty of times the researcher see individuals or one half of a couple. He like to steer the sessions towards couples work when possible. This seems to be a similar case on-line.

I almost always suggest that both should be involved…of course if the relationship has ended that is often not an option. I have truly found that both MUST be involved to have an accurate picture of what the issues are. I never cease to be amazed at how each person can be so oblivious to what the issues are… (Steven)

As quoted earlier, Justin notes the sentiment that work with three or more family members at once is less common at this stage.
The last tier are people seeking family therapy…I think that is still a very new field for on-line services, because, to be effective the video is really part of it…as with couples counseling too. (Justin)

Power

The researcher mentioned early in this chapter that there were some themes that were expected to arise based on the nature of the study questions and the interview protocol, yet there were other themes not anticipated, but noticed as a trend when the data was analyzed. Two unexpected ideas that arose were related to the power and anonymity of clients. After seeing what the experts were explaining about power, and how that issue seemed to be affected by the factor of how the therapy site was structured, the researcher wrote about it in his research journal.

The type of site and how it is set up apparently makes a big difference in the process and feel of therapy. The concerns of one therapist I interviewed seemed to be related to the way the site was set up, while others on another site would never think of the concerns because they wouldn’t happen. Example: Steven said, “most sessions are 45 min to an hour F2F, on-line sessions are at the mercy of the funds supplied…we are literally cutoff when the money is gone.”

On some sites, the client can decide to just add some more money or the therapist has the option to let the session continue for free. If you have those options, you are not at the mercy of the client’s funds. Something that stuck out to me related to this issue is that for Steven, there were structural things that could hinder the therapy process. The site he uses was created by non-therapists. Another site that was created by therapists did not seem to have the same drawbacks and lack of control for the therapist. Another instance was related to how much power the client had vs. the therapist.

On one site, it was set up such that each therapist had ratings and reviews. That participant felt at the mercy of clients to get good reviews and therefore found himself less directive & more interested in letting the client control the process. The important lesson is that the way the site is set up, structurally, has a major impact on the dynamic of the therapist/client relationship. No matter what choice is made, there will be tradeoffs, but those choices need to be made with care and with the interest of the client in mind. (Journal)
When the researcher asked Justin about any changes in approach to therapy in the on-line setting, he mentioned being less confrontational and explained, “I may now and then be a bit provocative and challenging, but less so on-line than in person simply because in person they cannot just hang up on me...” (Justin). Steven also had some opinions and experiences related to changing your approach on-line:

Steven: and traditional boundaries and "rules" don't exist...if an on-line client wants to ramble on about irrelevant issues, you often let them...as they are paying...and directing what WE do...some may deny that, but it is the clear reality to me

R: Face to face clients pay as well. Does that mean therapists should let F2F clients ramble on?

Steven: No...but it occurs more often on-line I assure you

R: More of an explanation, not a justification...

Steven: Let me say it is more client directed than F2F

Steven: F2F

Steven: ........"I want to talk to you today about.......and let me give you the background.......................40 minutes later they may say something relevant.......but they are saying what they want known......I guess it isn't as stark a difference, but still a difference....... 

You can see that the researcher challenged Steven about the responsibility of the therapist to guide the session and not simply let the client ‘ramble on,’ but Steven indicated that in his experience, the dynamic of an on-line session affects that interaction and shifts the power more toward the client.

Anonymity

Related to power, anonymity seems to shift the power differential in the therapeutic relationship. The researcher does not feel the need to make a judgment as to
whether this is a good, bad or neutral phenomenon, but it is something that an Internet-based Family Therapist should be aware of.

Clients may question the authority or expertise of the therapist and the therapist may not even be certain that the clients are who they say they are. Depending on whether the sessions are text based or video, there may be varying degrees of actual or perceived anonymity. One could also argue that just as an on-line client could use a fake ID or someone else’s credit card, it would be possible to do so F2F, but that seems less likely.

Natalie shared an anecdote about her expertise being questioned by an on-line client.

Natalie: bt i [sic] did have one questionable one…she very regularly [sic] questioned me…but we were able to work through it…by addressing it on very regular basis in sessions

R: When you say, 'questioned me,' what kinds of questioning?

Natalie: not sure how good i was or not accepting help but still wanted to be in sessions

R: oh, okay.

Natalie: as well as questioning therapy in general especially on line but she has refused to go to face to face therapy…since she has been ibn therapy before face to face and she felt that the therapist judged her for her looks

R: Wow, that would be interesting to deal with on-line - especially if there was no video involved.

Natalie: yep

Natalie: when she described herself she was probably a very beautiful woman

Steven brought up concerns about knowing the true identity of on-line clients.

Again, notice that some of his opinions seem to be heavily impacted by the site structure.

Steven: Concerns: identity…Do we really know WHO we are talking to? and in [site redacted]'s case, the clients determine what THEY pick for their
username, unless they want a random one assigned, like "User_CBVDF" most pick…”Lonely" "Worried" "Sally" etc…what confidentiality is there when we don't really know who we are talking to?

R: So there is more anonymity.

Steven: Persons seeking 100% anonymity have a real opportunity to present themselves as…someone else…different gender/race/religion, etc…Many Military people are terrified of their issues being known on base…for fear they will be stricken from certain hazardous duties, scuba diving, combat, demolition, etc

Later, in the section on ethics, the researcher shares his question about what this means for certain ethical situations (duty to warn, etc.) and Steven’s response.

Earlier, the researcher shared that Justin noted a “feature” of Internet-based therapy is anonymity, which is “kind of gone” with video therapy. There would still be anonymity in the sense that no one will see the client going into a therapy office or see them sitting in the waiting room, but, granted, there is an even higher level of anonymity when the sessions are text based.

One last note about anonymity that came about from the experiential part of this study is that the researcher had at least one participant assume that he was a female because of his name. This would be one thing to make sure and find out when doing text based therapy, especially with gender-neutral or unisex names (e.g. Chris, Alex, Mel, Pat, Sam).

In the literature: client issues

The Client theme helped to address the question of what client types and presenting problems can be addressed on-line. Mallen, et al. (2005) suggest that Internet-based therapy would work better for people that are higher functioning. There are recent articles that study working with clients on a variety of presenting problems and client
types such as alcohol use, couple’s therapy, family therapy dealing with a child’s brain injury, family therapy for adolescents with chronic pain, depression and anxiety (Blankers, Koeter and Schippers, 2011; Carey, et al, 2008; Palermo, Wilson, Peters, Lewandowski and Somhegyi, 2009; Pinsof, Goldsmith and Latta, 2012; Wade, et al, 2008). Online treatment of individuals and couples dealing with sexual issues is also being studied (Van Diest, et. al., 2007; Pinsof, et al, 2012). Bell (2007) studied clients dealing with panic disorder, phobias, anxiety & PTSD and how they might be helped through therapy on-line.

*Core Theme 4: Face-to-Face Is Better Than Internet-Based Family Therapy, However Internet-Based Family Therapy Is Better Than Nothing*

One easily expected theme was the comparison between traditional face to face family therapy and Internet-based Family Therapy. There were some comments shared about similarities and differences between the two mediums and there were also positives of Internet-based therapy over F2F as well as negatives of on-line vs F2F.

*Similarities*

The researcher noticed that several therapists alluded to the fact that many processes occurring with Internet-based Family Therapy are quite similar to F2F therapy. Sessions can just as easily take place once a week. Edith mentioned session length being the same for her. “The first session as in my face-to-face sessions is an hour and a half and subsequent sessions are one hour in length” (Edith).

There were a couple comments that suggested video, in particular, much more closely approximates F2F work. Andrea was already quoted as saying that with the state of internet video technology, Internet-based Family Therapy is “almost as good as talking
face to face.” Justin was also already quoted as suggesting “Video is very close to face to face IF the connection is good and there is no time lag…”

**Differences**

The differences between on-line and F2F family therapy that participants shared mostly, but not totally, seemed to point out drawbacks with on-line work. There are more similarities and differences discussed and they will be elaborated upon in the forthcoming sections “Pros” and “Cons.”

Justin said that reading non-verbals is good “if there is no lag time” Although this could be seen as a similarity, it is a difference, in that there is no such worry about lag time in a F2F session.

In a response to e-mail follow-up questions, Natalie noted one difference with on-line work. “It is more difficult to do family work because then everyone has to be on either a speaker phone or skype” (Natalie).

It was already mentioned that Steven suggests the therapist is forced to have more client-directed sessions, which could be a positive or might be a negative. When the researcher was interviewing Andrea and discussing some disadvantages, she mentioned the client’s view of the therapist’s professional status.

Andrea: Convincing of my legitimacy as a therapist

R: Convincing the clients?

Andrea: It's hard for people to trust people over the Internet - understandably

She also mentioned some positive differences.

Andrea: Well, I think it's interesting how people can be less inhibited meeting a therapist in their own home - so to speak

R: Explain
Andrea: Especially for couples with video therapy, I will see their dogs, their decor, witness them dealing with distractions

Andrea: Gives me more insight into their day-to-day lives.

One negative mentioned by Edith pointed to the fact that some things may be lost in (electronic) translation even when doing video chat.

Edith: A second issue is the loss of clear reading by the therapist of nonverbal communication. As you are not with them in person, there are things you miss.

R: So, you feel that even when you are doing video chat, it is more difficult to read non-verbals?

Edith: Yes, when in person, you get an immediate "sense" of the state a person is in. For example, if they are depressed or angry, there is a heaviness. You also can miss subtle cues.

*Text vs. Face-to-Face*

There were a few miscellaneous comments that pertained to text chat family therapy vs. F2F dealing with writing skills, non-verbals and flexibility that were worth sharing. The researcher already quoted Steven saying that the writing skills of the clients makes a big difference in the interactions. The quote leading into this section talks about the loss of non-verbals even in video chat. It is that much more true with text chat. Steven speaks to this as well.

It may be easier to hide issues by not having facial expressions/voice intonations, eye contact seen…and you can't see…or often hear the other persons responses to the first's expressed issues..............."She NEVER lets me........" and can't see the wife's look of disgust or happiness. (Steven)

In contrast to this particular negative, an earlier quote from Andrea says it is “interesting in text-based mediums because they can ‘see’ what the other person has said…makes it harder for couples or parents & childrens [sic] to talk over each other.”
The researcher noticed something during his text-based interviews that felt like more freedom or flexibility compared to doing F2F therapy. He wrote about it in his journal. “If I get antsy in one of the sessions, I can stand up and pace for a moment. I don’t do that as a therapist in session face to face.” Walking around would not be a good habit to be in when doing Internet-based work. As a rule of thumb, therapists should eliminate as many distractions as possible. It does not seem wise to be folding laundry while doing a text-based family therapy session.

*Hierarchy*

This theme (i.e. F2F is better than Internet-based Family Therapy, however, Internet-based Family Therapy is better than nothing) is most precisely summed up here. All five participants specifically gave an unsolicited opinion that they consider F2F to be more preferable to on-line work. Whether saying it should just be supplemental, a second choice, less effective or that it is not as good, they indicated a hierarchy between the two. They did tend to add the caveat that just because they believe F2F is better, doesn’t mean that on-line is bad and given that it is sometimes the only choice, better than no therapy whatsoever.

I believe Internet-based therapy should be an adjunct, rather than a main source of therapy because of many obvious limitations, including time constraints, financial limits and not being able to clearly define how often you will be in contact with the person. (Steven)

I tend to think of Internet-based therapy as second choice--when face to face is not possible. Thus, I've done counseling over the Internet that I would prefer to do live, but it is the only option. (Edith)

Online counseling for families is not as effective as in person, thee [sic] is little doubt about that; but, the convenience can compensate, and for people in rural areas, or small communities, or where a family therapist is difficult to find, Internet-based Family Therapy can be a great advantage. (Justin)
I would say that there are many times when face-to-face therapy is better for the client. But I wouldn't say other forms of therapy aren't therapy. Just that it might not be the right choice for everyone. (Andrea)

When the researcher asked Natalie what some specific concerns are for family therapists regarding the Internet, her response was “That it’s not face to face.” What is particularly interesting was statements coming from people that actually do Internet-based Family Therapy, without even being asked, specifically, if on-line or F2F is better, they submitted that on-line is second choice. That is a strong statement coming from the people most likely to champion this type of therapy.

In the next couple sections, we will delve more into the positives and negatives of Internet-based Family Therapy, which should more fully develop and illustrate this theme and why Internet-based therapy is better than nothing at all, but how it may not fully measure up to therapy in an office setting. The descriptions given continue to shape a picture of the phenomenon of Internet-based Family Therapy as experienced by the therapist.

Pros

There were four positive aspects of Internet-based Family Therapy that were found during the data sifting and organizing process. The experts talked about the convenience of the medium, the fact that it is sometimes the only option, how it can help to create a feeling of safety, and mentioned positives for the therapists themselves. Other positives are mentioned as well, which will be evident throughout this section.

Convenience

When the researcher asked Justin his thoughts about the advantages of Internet based therapy, he gave the following response:
Convenience is a major advantage...cost can be another, it is often less expensive. Worked well, the introductory part of it, ie, the psychoeducation piece, can be very convenient, [sic] effective and affordable...in some cases, anonymity is a big advantage...you can live in a very small town, and have counseling outside of your community, ensuring your privacy without leaving your community. (Justin)

He also mentioned in a different part of the interview that scheduling doesn’t take much effort. “Scheduling is pretty easy and on-line counseling is very convenient for most people” (Justin). Natalie noted the positive time factor and flexibility:

Its has been great for both the therapist and the client...for the therapist its convenient and its remote type of work...you can do it from anywhere...for the client many times its beneficial because sometimes it saves them time it allows them to also be remote it gives them an opportunity [sic] to be flexible it give them a chance to coomit [sic] to therapy without going to the office...many clients suffer from anxiety and this method works for them because a) they don’t [sic] have to necessarily do face to face...it takes away from being fearful of judgement [sic] or shame or embarasment [sic]...sometimes people dont [sic] have access to transportation or wont leave their house. (Natalie)

At least one of the sites used by one of the participants had “round the clock” availability. Steven spoke to this advantage:

Number one...it is available 24 X 7. A crisis is best handled NOW, not...Next Thursday at 2:00...I don't mean a 911 crisis, but someone feeling they are in crisis are best served right NOW, not at the next available appointment. (Steven)

Only option

One of the most common comments suggesting that Internet-based Family Therapy could be a good thing, and therefore supporting this theme, is the line, “Sometimes it’s the only option, and it’s better than nothing.” Early, Edith was quoted as saying there are times she did Internet-based therapy that she preferred to do F2F, but on-line was the only option. As was just quoted in the last section, Natalie shared that anxiety and other issues may keep someone from going to an office altogether. When
parts of a given family live in disparate locations, they may not be very likely to do therapy simply because of the travel time involved. Andrea spoke to this idea.

[Internet-based Family Therapy] has a lot of potential application in today society - I would like to see it used more w/ active duty military, and parents & children in other states. Dr. [name redacted] - my former supervisor - once had a mother and daughter drive two hours each way - one south, one north to meet her! W Internet-based Family Therapy that wouldn't be necessary. (Andrea)

Sense of safety

One of the ‘only option’ categories discussed in the literature is agoraphobia, so anxiety and/or agoraphobia have been submitted as reasons for some clients to benefit from Internet-based Family Therapy. For those clients, the on-line environment may be a ‘safer alternative’ where they can still get help. The goal in some of those cases may be to lead into F2F sessions once the anxiety level has diminished adequately. The sense of safety also has the benefit of letting clients open up more quickly according to the experts interviewed in this study. In Edith’s experience, clients get to the core issues faster on-line. She gives some potential reasons as to why.

As previously stated, there are times when it is the only option. Another therapist may not be available, so it offers the opportunity for anyone, anywhere to receive counseling. Another advantage is that clients tend to get to the heart of the matter quickly. There is less chit chat. I think this is due to the sense that time is limited and technology is not always reliable, so they jump in. A third advantage is there seems to be a sense of safety--almost invulnerability as they are distant. It sometimes encourages an openness to occur sooner than in face to face therapy. (Edith)

In an earlier section, Andrea was quoted as saying people can be less inhibited meeting the therapist in their own home. The comfort level of being on their own ‘turf’ could add to that feeling of safety. When Natalie mentioned Internet-based therapy helping people that wouldn’t do F2F, she specifically mentioned adolescents and how they are more willing to do on-line sessions than they are to go to an office.
For example adolescents…it is so much easier for them to just sit in their room with door closed and do sessions without having to go through many hoops that are attached to the office sessions…many teens will not admit that they need help but doing it on line gives them a different way of looking at it. (Edith)

Pros for therapist

Since the goal of this study was to better understand the process of Internet-based Family Therapy from the perspective of the therapist, it was helpful to get feedback expressing positive aspects of Internet-based therapy for the therapist him or herself. “Pros for the therapist” was yet another minor theme that was unanticipated during the data collection phase of the study.

Natalie made some points about the flexibility it offers for the therapist because he or she is not necessarily tied down to an office. “Its has been great for both the therapist and the client. For the therapist its convenient and its remote type of work. You can do it from anywhere.” A little later in the interview, she mentioned how it can help with the logistics of dealing with her children. “I have enjoyed it. I have small kids and it was convenient for my flexibility” (Natalie).

The “only option” idea is typically applied to clients. However, not only can Internet-based therapy offer flexibility for a therapist, but sometimes it may even be the only option for him or her as well, which had not crossed the researcher’s mind. Andrea explained that she was in a situation where F2F was not an option for her.

Right now I am doing no face-to-face - it's a long story, but I followed my husband to school in an area that is saturated with counselors. So I have not been able to get any face-to-face work. (Andrea)
Cons

Just as there were positives expressed about their on-line work, the participants shared different negatives that they have encountered on-line. The following section takes a look at those issues.

The negative aspects that were articulated by the experts included a lack of non-verbals, privacy concerns, a lack of depth as well as some other concerns. This speaks to the part of the theme that says “F2F is better.” Some of these issues also touch upon ethical concerns and are therefore elaborated upon even further in that section of this chapter. Further, the potential problems related to technology, such as a computer crashing, were already discussed in the Practical Technical Issues section and will not be repeated here, but the reader should keep in mind that those technical issues can be seen as negatives.

Lack of non-verbals

There were several comments about the lack of non-verbal communication when doing Internet-based therapy. Most of these comments tended to be related to text-based chat, but it is also possible that non-verbals do not translate as well over video as they do F2F.

Justin pointed out that body language as well as vocal intonation are not conveyed depending on the modality of therapy: “For live chat and telephone one of the disadvantages is not seeing…no body language…with chat, no tone of voice…” Steven shared the same sentiment: “Of course, up until recently, the majority of interactions were via "chat" or instant message as we are now. We do not see body language,
identity, eye contact...level of engagement is difficult...voice inflection [sic]...etc., is also not there…”

A lack of visuals can impede one-to-one communication (therapist to client and visa versa), but also seeing body language between clients within a couple or family. It can also hinder the rapport building, according to Steven.

It may be easier to hide issues by not having facial expressions/voice intonations, eye contact seen...and it may be easier for a dominant member to completely overshadow a more timid partner...Imagine rapport building...the APA has said it takes 6 months. I may talk to someone right NOW if they had a need too and knowing rapport is achieved is difficult...I guess the test is IF they call back...and you can't see...or often hear the other persons responses to the first's expressed issues..."She NEVER lets me…” and can't see the wife's look of disgust or happiness. (Steven)

This next passage from the interview with Natalie transitions into the next section well because it mentions non-verbals as well as privacy concerns.

R: What are some specific concerns for family therapists regarding the Internet?

Natalie: that its not face to face. that at times a therapist cant see the body language or emotions possibly misinterpret the content. sorry for the misspells if any

R: No problem. So it sounds like most of your concern relates to how well you connect or communicate with clients

Natalie: yes, there are some other once. confidentiality is another one. you are not sure who else is in the background. that why I used to prefer phones contact at times either by itself or at time in conjunction with the chat

R: I don't know that I've given that much thought - you can't control their environment during the session.

Privacy

Privacy concerns ranged from keeping their information secure on-line, not being sure of who is on the client’s end during the session to simple interruptions from the
client’s children. Andrea mentioned “Privacy of information,” which could include online account information or text from an actual session. It can work well for a site to have proper encryption and also to not save any session data. There is always a possibility that the client can copy and paste the text from a session and they would be responsible for its security. A therapist should make sure in the informed consent that they are aware of the risks involved with this.

Privacy and confidentiality can be an issue, especially with skype or chat, like this. I inform clients that though I keep everything private and confidential, nothing on the Internet can be fully guaranteed to be private and confidential. (Justin)

As Edith shares, the privacy concerns are not always an issue of ethics and breaches of confidentiality, but may simply be that a client needs privacy from other family members while the session is taking place so that they can concentrate. “Concern about confidentiality, interruptions from others walking through (such as children)” (Edith).

Lack of depth

The comments related to a lack of depth were mostly about how deep the relationship between the therapist and client(s) gets. By association, if the relationship is not very deep, the therapy itself is not as likely to be very deep. The researcher wrote about this topic in his journal.

What about rapport? Several therapists mentioned how people are more likely to dive straight into their struggles. Someone else noted that APA says it takes 6 months to build rapport. Does that mean in the on-line setting, some clients just skip over that part of the process? If true, is that good, bad or indifferent? My intuition reacts by saying it is bad. One point of logic says, “Hey, they’re addressing their problem,” but at the same time, they may be missing out on the important process of practicing relationship building. (Journal)

Steven said, “it is too easily the HERE and NOW, rather than what's beneath the service and what isn't being told to us.” Andrea labeled it as the medium “creating distance
between counselor and client.” She has experienced one kind of distance where the client is not willing to get as close because they don’t know if they can trust that the therapist is genuinely qualified.

Andrea: Convincing of my legitimacy as a therapist

R: Convincing the clients?

Andrea: It's hard for people to trust people over the Internet – understandably

Additional concerns

There were some more concerns that did not fit neatly into a specific category, but were nonetheless negatives. These problems were issues like accountability, buy-in, client’s level of tech savvy, time & financial limits and deception by clients.

According to Andrea, clients may not take their commitment to the therapy process as seriously when doing it on-line. They may be less invested.

for me personally I have struggled with instilling accountability in my clients to come to sessions...difficult in any circumstances but many people seem to think it's less important to prioritize your mental health because you're "doing it on-line." (Andrea)

She also noted, later in the interview, that different family participants may be more or less engaged in the process. In this same sentence, she made a statement about another negative associated with Internet-based Family Therapy: the digital divide.

When one member of the family group is less interested in therapy, which happens often, it's easier for them to "get out" of it, sometimes the parent's generation understanding technology. (Andrea)

In his follow-up e-mail response, Steven added some more concerns for the medium.

“Many obvious limitations, including time constraints, financial limits and not being able to clearly define how often you will be in contact with the person” (Steven). He also
talked about how the clients may be deceptive or manipulative. There were more

comments related to this idea in the earlier sections about client power & anonymity.

Well…you know how we often may be fed a story or directed to something that is
NOT the real issue…Naturally it would be easier to be "hoodwinked" on-line by
the client throwing a bone for us to chomp on…I often worry about the clients
using us to "Affirm" their desired take on a situation. "Honey" Even [Steven]
said…that we shouldn't…xxxx. (Steven)

One issue pondered in the journaling process related to having a site and deciding
whether a therapist should create his or her own vs. using a previously established site.
There would be a great deal of up-front cost associated with creating a well-made, secure,
encrypted, professional therapy site. If the therapist chose to use an established site, they
are at the mercy of the creators regarding how well it is set up and how well it helps or
hinders the therapy process.

Is it therapy?

Yet another unexpected minor theme that arose during the data collection process
was the question of whether or not Internet-based Family Therapy even counts as
therapy. Steven seemed to have the strongest opinion about this matter and had obviously
done a great deal of thinking on the topic. The participant experts already shared that they
do not consider Internet-based therapy to be on the same level as F2F. This section will
convey some thoughts to see if therapy is even the proper term.

Earlier Justin was quoted as saying, “I wouldn't necessarily refer to that as
therapy, though part of it. For therapy, the role playing and interaction with the couple is
important, and for that video is needed.” This particular quote refers specifically to text-
based therapy. He did clarify that he does consider it part of the therapy process, but
mostly he uses it for psychoeducation.
Steven submitted some very interesting ideas that made me ponder this question about the legitimacy of Internet-based Family Therapy. He starts off comparing it to the work done on a therapy talk show.

Steven: Do you remember Dr. Phil a few years ago having a license board complaint levied as he wasn't licensed to practice psychology in the state his show was filmed at?

R: I did not know about that.

Steven: Well…the board ruled that his work on television was not the practice of psychology and they ruled he didn't need a license
Steven: RIGHT NOW, many states are considering how to handle on-line work
Steven: California currently REQUIRES their licensees to only work with California residents

R: I know plenty of therapists that wouldn't call his work psychology.

R: I know many of them get around that by doing 'life coaching'
Steven: How can that be enforced? How can those on-line therapists make any money when the bulk of all clients are all over the world…So they generally ignore that requirement and do what they wish

Steven: YES…but here's my argument…Online work is not real therapy
Steven: It is responding to the crisis, the "paid" presentation of their perceived problem, OR what THEY wish to discuss…so we are much more responsive to the immediacy of their concern, the customer orientation as they are paying out of pocket and their is an EXTREME effort to make the client happy so they leave a positive rating…

Steven: Just as Dr. Phil isn't REALLY practicing psychology, we aren't truly practicing, counseling, marriage & family therapy, social work or psychology, we are here for entertainment purposes and for crisis type issues…most calls do not rise to the formal intervention of a specific modality

Steven: and traditional boundaries and "rules" don't exist…if an on-line client wants to ramble on about irrelevant issues, you often let them…as they are paying…and directing what WE do…some may deny that, but it is the clear reality to me
Steven:…DON't get me wrong it is a good thing and I've helped many people…read my reviews…But it is "different" and in my opinion doesn't rise to the level of standard therapy…more like Dr. Phil, guiding, directing, etc…most of us do refer people to F2F for many issues.

Some of what Steven said in that quote, again, seemed to be colored by the particular site he uses for doing on-line work (e.g. pandering to clients in order to get high review ratings).

Earlier, the researcher shared a quote from his journal asking about rapport building with on-line clients, couples, and families. If rapport is of key significance in therapy and there is a question of how well that happens in this setting, that is one more notion that adds to the question of Internet-based therapy being actual therapy.

The researcher asked Andrea her thoughts on the subject and she gave a different perspective that was more on the positive, optimistic side.

R: A few people that I've interviewed - people that do on-line Thx - have mentioned that either they don't consider it actual therapy, or don't consider certain aspects (like the text chat) as actual therapy. Any thoughts about that?

Andrea: Well, people are afraid of change, especially if they don't completely understand it. I wouldn't make a blanket statement like that. I would say that there are many times when face-to-face therapy is better for the client. But I wouldn't say other forms of therapy aren't therapy. Just that it might not be the right choice for everyone.

_In the literature: Internet-based vs. face-to-face family therapy_

Comparing family therapy over the Internet with work in an office is a natural inclination when examining Internet-based therapy. A few different studies worked to compare the two. One article talked about a controlled study comparing Internet-based therapy, Internet self-help and ‘no treatment’ for the treatment of alcohol use. They claim that Internet-based therapy can be effective compared to no therapy at all (Blankers, et al,
One article talks about advantages and disadvantages of Internet-based Family Therapy, particularly noting the issue that several participants discussed - a lack of nonverbal communication hinders the process (Pollock, 2006).

Much of this last section dealt with “Pros & Cons” of on-line work. In their research, Gilkey et al. (2009) looked at the ‘merits and shortcomings’ of on-line (video-based) therapy and note some of the same issues discussed above. Haug (2009) worried that the therapeutic relationship would suffer in an on-line setting, while a study found not only a positive with the accessibility of Internet-based therapy, but also found that participants experienced the therapeutic relationship as strong and positive (Wagner, Knaevelsrud & Maercker, 2006).

Core Theme 5: Theory Use Online Is Much The Same As In Face To Face

The following section deals with theories and techniques that work well with Internet-based Family Therapy, as well as those that are contraindicated according to the participants. This theme showed up in two ways. Sometimes participants directly said theory use on-line is similar to F2F. At other times, they described theory or technique and it was described in a similar fashion to how it is typically done in an office setting. The theories section is fairly straightforward. The answers about technique tended to be less about therapeutic techniques related to a specific theory (e.g. prescribing the symptom, asking the miracle question, etc.) and more about techniques that make the communication and interaction on-line work more smoothly (e.g. reducing the length of pauses/silence, being more overt with words since there may not be body language, etc.).
Theories

Participants shared thoughts about theory that fit into four main categories. They said that on-line work is done using MFT theories in the same way they would for F2F sessions. They talked about theories they did not think work well on-line. They shared the different theories they do think work well on-line. Lastly, they talked about some that can work on-line, but really need video to be done properly.

 Mostly similar

One of the main themes found about theories as they relate to Internet-based Family Therapy is that the theoretical aspects of therapy hold true even in on-line work. The researcher wrote about this in his journal:

Much of what is discussed about on-line sounds like face to face. There may be more similarities than differences. There may not be a high level of salience regarding differences vs. similarities. I notice that the responses related to ‘what theories do you use for Internet-based therapy’ tend be explained as – ‘it works in the same fashion as face to face sessions’ – as if to say that there are no particular theories that are well- or ill-suited for on-line use. Maybe it is that the theories mentioned (e.g. CBT, Solution-Focused, Narrative) have some programmatic aspects to them that work well on-line and can have similar processes on-line and F2F. As I think about it, nobody is saying that they use some other particular methods/theories (EFT, EMDR, Hypnosis) – maybe because they just know inherently that these are not well suited for on-line use. Someone did mention the potential for Experiential – This could make sense if there was at least a video session taking place, because the visuals would make a difference. A potential area for research would be to go through different theories, analyze the different principles and techniques with on-line work in mind and consider which things would be hindered and which would work well. This could be followed up by doing studies about the efficacy of different theories/methods in on-line vs. F2F.

(Journal)

In response to the follow-up e-mail questions, Steven mentioned Structural as problematic if you do not have involvement from the entire family and also brought up a philosophical idea about the use of theory.

Structural Family Therapy is difficult as not all participate at once…I think there is often admittedly a lack of coherent use of theories. In other words we do what
we do in response to the client and time constraints…often using our knowledge of theory, but not directly adhering to a specific theoretic approach. (Steven)

This type of statement is one that a therapist could say when referring to F2F or on-line work. The other participants explained their thoughts about the similarities between the two modalities.

R: What particular MFT/systems theories have you found fit well with therapy over the Internet?

Natalie: cognitive and solution focused

Natalie: more of short term once

R: Can you speak at all to how these get used on-line and how it would be similar/different than using it face to face?

R: it wouldn't [sic] be different

R: as far as techniques & such, you don't see much difference?

Natalie: as a matter of fact its very similar you still use the same techniques and tools and homework asignemnts [sic]

Natalie: i didnt [sic] experience much difference in doing face to face or on-line

In a follow-up e-mail response, Natalie added, “I do a lot of cognitive behavioral work and again it is very similar to what I do with my clients in private practice. So I really haven't experienced much limitations.” When asking Justin about theories, he gave this answer:

R: Also, do you feel the need to change approaches (from a theoretical standpoint) when on-line vs. face to face?

Justin: I don't feel the need to change from on-line to face to face…its pretty much the same…
Another idea that Justin brought up was “that to do Internet-based Family Therapy, the therapist needs to be well grounded in MFT theories already.” He noted the importance of having F2F experience to get a good understanding of theories and technique.

Justin: A therapist needs to be very comfortable with basic family therapy principles and practices to engage with in on-line because there is still this 'distance' between participants…a family therapist is often directive, guiding, pointing out things, maybe challenging, though softly on-line…being attentive to what is seen, on video…and commenting…Internet-based Family Therapy would not be the way to start out in family therapy…

R: That's a good point. I've seen articles recommending that Internet-based therapy be taught as part of a curriculum. Would you see that as a bad idea in light of your last statement?

Justin: I think it would be a good idea, with caveats that some aspects of some counseling/therapy [sic] on-line be reserved for after a year or so of direct face to face experience

Edith shared a similar sentiment to other experts, saying that many theories would be appropriate for on-line work with the caveat that experiential theories could be tricky. “Any of the MFT/systems theories work well. Those more experiential in nature are going to be more difficult, but even sculpting could be done if desired” (Edith).

Thus, if the theory aspect is “mostly similar” on-line and F2F, then how are they different? In an answer to the follow-up e-mail, Andrea addresses how one would adapt certain parts of the therapy process for distance family therapy.

The main change you would have to make for a family therapy model to move to an on-line model is to modify physical techniques to be described or visualized instead of actually practiced. Drawing & mapping could be done by the computer-savvy therapist through use of a screen-sharing application. (Andrea)

Contraindicated theories

The therapists explained how they see much in the way of similarities, but they also had ideas about theories that would not work well on-line. Earlier, the reseracher
shared an excerpt from his journaling process saying that none of the participants said they think EFT, EMDR or Hypnosis would be good on-line. Those all seem like they could be lacking something significant if done on-line. The researcher had a conversation with a colleague that does EFT, and he mentioned that there are people in England doing on-line EFT with people in the states. He was making a point about crossing state lines, but it stuck out to me that they were doing this particular kind of therapy on-line. This would indicate that some therapists think that it does work.

Even in suggesting that many theories would work on-line, hypnotherapy was specifically mentioned by Andrea as potentially contraindicated. “Most can be adapted, but hypnotherapy would be difficult, I would imagine” (Andrea). Steven said that Dialectical Behavioral Therapy “is out, due to the group component.”

There was not much else said about theories that should not be used on-line. There were more comments about what theories could or do work well on the Internet.

*Well-suited theories*

There were similarities in the answers given by the participants when they were asked what theories they use. They ranged from brief, solution-focused to narrative to CBT and General Systems Theory.

R: What particular MFT/systems theories have you found fit well with therapy over the Internet?

Steven: Certainly CBT, solution focused and crisis theory are used frequently brief interventions are the norm

— Edith: I primarily use Narrative therapy and multigenerational therapy.

— Natalie: cognitive and solution focused more of short term once

— Justin: Cognitive approaches work well, and fit nicely into the psychoeducation part…Systems theory also fits well into the education piece; the couple
need to have some understanding of how that all works…but, when it comes to some role playing and implementation, [sic] then video is more important…

R: So, as far as role playing, that could fit in with Experiential. Am I hearing that right?

Justin: Yes, experiential, which is an important part of structural/systems family therapy…

Andrea: I find that general systems theory works well in this environment

R: Can you speak at all to how it works well on-line?

Andrea: While I don't necessarily use tools of structural family therapy, I find that thinking works well too

Andrea: I talk to clients about family roles, how one action impacts another…

R: the mindset informs how you proceed…

Andrea: yes - I talk about the "family dance" of family of origin with each premarital couple

Needs video

Anything visual or active is going to need video in order to execute well. Justin made a couple of comments about this. In talking about Experiential therapy, he said the following. “When it comes to some role playing and implementation, [sic] then video is more important” (Justin). In the e-mail follow-up, he added this statement. “Unless using video such as Skype, doesn’t work too well for Structural family work, ie, [sic] having the family members take physical positions, act out certain roles, etc” (Justin).

Technique

As mentioned in the introduction to Theories & Techniques, the answers about technique did not have to do with theory-specific techniques. The researcher made a note about this in his journaling process.
I had originally expected more answers about technique to be theory specific. I found that most of the answers were more about how to clearly communicate given the limits of on-line work. My hypothesis as to why they did not talk more about technique as it relates to theory is that many techniques would end up working the same way if they were F2F or on-line. For example, if I ask a client some form of the miracle question, “If therapy is successful three months from now, what would you notice being different about your life?” the answer could be very similar whether the family is F2F or on-line. Similarly, some alteration of the ‘empty chair’ technique, “If Steven were involved in this session, what do you think he would say about that?” as opposed to literally pointing at an empty chair and asking, “If Steven were sitting there, how would he respond?” (Journal)

The only real answer related to theory-related techniques came from Andrea. She had an insightful answer in the follow-up e-mail.

CBFT (examining irrational beliefs, shaping, therapeutic contracts) and family systems. A kind of structural family therapy can be practiced (albeit in a limited manner) if you have permission to share written materials with other family members, this can often help them see things that they weren't listening to in verbal communication. I also sometimes "prescribe the symptom" and ask them to report back on how that went. I also use some elements of narrative therapy, such as defining the problem as a separate entity from the person or family. (Andrea)

It was she that had also mentioned something about explaining the ‘family dance’ with clients earlier.

There were a few answers about specific techniques that are dependent upon the medium, such as a family sculpting exercise needing video. The answers fell into one of three categories, either general techniques, text-specific techniques, or techniques used when doing video-based work. The next few sections break these down.

**General**

There were a few pointers that participants gave about procedures a therapist might want to use in the on-line setting. Since part of the research was experientially based, the researcher dealt with some issues that could easily take place in Internet-based therapy. This led to some pondering for the journal:
Even though I consider myself tech-savvy, I felt some level of anxiety going into the ‘virtual therapy room’ for the first time waiting for the participant to join me for my interview. That was for me doing an interview. I imagine that a client with the added stress of their presenting problem could easily feel some stress waiting for the session to begin, wondering if the therapist will actually show up. By the time I did my fifth interview, that stress dramatically lessened, so I don’t put much weight on this issue for the long term, but it could be useful in determining what is said in the informed consent, i.e. what kind of assurances are given to allay initial fears. (Journal)

Steven shared a thought about how to start the process off, which again, is quite similar to what a therapist might do in F2F therapy. “I first address the presenting issue and gain as much information as possible, how long married, how long as the affair been going on, are you separated? Does he/she want to remain married?” (Steven).

Some techniques may be altered for the on-line setting because of the limits inherent in the medium. Justin explained how he may not confront clients in the same way on-line. “I may now and then be a bit provocative and challenging, but less so on-line than in person simply because in person they cannot just hang up on me” (Justin).

Steven gave some practical advice about sharing information with or assigning homework to clients: “Most of the sites allow for email or ‘file sharing’ I often send informational articles, homework, questionnaires, etc., to clients via this resource. I do not use genograms as a rule…or other drawing but do often provide ‘homework’ or send helpful documents” (Steven).

Text

There were several helpful ideas shared about both text-based and video-based Internet-based Family Therapy and different techniques that work well for each medium. Many of the text-related techniques had to do with the flow of the conversation and being
thoughtful to the clients, making sure that you understand each other and are aware of the potential spots of miscommunication.

When interviewing Steven, the researcher pointed out something related to text-chat techniques.

R: Particularly with text-chat, it seems that therapists need to re-learn what it means to listen, be empathetic, stay focused, allow for 'silence,' etc. because those look quite different.

R: …on-line

Steven: right and silence is not welcomed…"are you there?" "I'm paying for this"

In journaling, the researcher also wrote about the pacing when using text:

With one participant that used shorter sentences, I would assume that their short answer was all that they had to say, but when I didn’t respond right away, they kept adding to their answer. I saw that if I just sat and waited, they kept giving more story. I have been well aware of this phenomenon in F2F interaction, but the timing was different on-line in a chat, so I had to re-learn that lesson. There is more of a time delay, so it takes even longer. (Journal)

The researcher also picked up on a technique that Justin was using during the interview that was nicely accommodating:

R: By the way, I noticed you doing something that is a good communication skill with the chat interaction. If you are giving a longer response, you'll add a "..." to let me know you have more to say. That seems helpful.

One of the participants (Justin) wrote about how they deal with the timing issues by avoiding typing out long paragraphs. “I try to keep my responses brief and send often…so they know I' here and responding the typical therapeutic stance of silence and observation doesn't really work here...:)” (Justin). Tracking a client’s pace and matching is something one can also do in the on-line setting, as the researcher wrote about in his journal.
I noticed that different participants used different writing styles. Some in narrative, paragraph form, others in short sentences. Some used proper punctuation while others were all lower-case. I found myself naturally conforming to their style. I seem to remember hearing that as a recommendation in a seminar – as a way to keep the client from feeling lower-than or judged. It’s an on-line parallel to matching in a face-to-face session. (Journal)

There was an exchange with Andrea that included some talk about the use of emoticons and also a suggestion and an explanation about why it is good to use names for on-line sessions. Part of the dialogue had to do with video, so it is placed here to lead into the next section.

R: Also, I noticed that you are using emoticons. Do you in session, and if so, can you speak to their use?

Andrea: Yes, emoticons help to a) make you relatable, because most people use them and b) help make up for lack of visual cues.

R: Some other therapists I have interviewed don't use them. I don't know if that has to do with age, 'tech savvy' or other factors, like thinking it takes away from professionalism. I can see how it would be helpful. Also, to make up for non-verbals, I've heard the suggestion to say something like, "That makes me scratch my head," or "I'm confused."

Andrea: I agree with both approaches. I'm younger, and my major demographic is college students. They appreciate emoticons. In person I'm probably more "casual" than many older therapists would be, but my "appeal" to this age group is the idea that I've recently shared their experience.

R: Can you speak more about the actual process of interaction when you are seeing multiple parts of a family at once?

Andrea: You have to be careful to use names so they know who you're talking to

R: Good point

Andrea: Even if video, it's hard to tell who you are facing, like in a family session in an office you would incline your head, point, reorient your body…you can't do that on video. It doesn't translate

Andrea: and of course when you're in a chat session with multiple people, they don't know who you're talking to if you don't use names
Video

Aside from the previous quote, there were only a few comments made by the participant experts that specifically had to do with techniques used in video-based family therapy. The first two had to do with practical matters.

I meet clients (when we have live videoconference sessions) in a designated office in the house. It has plain walls and the client can sometimes see an artificial plant, a framed copy of my LPC license, and the edge of the couch. This was done deliberately so that clients will feel more like they are meeting me in my office. (Andrea)

Edith said, “Another issue is looking into the camera so it seems you are looking at them. This helps them feel more comfortable. You cannot see the screen as easily.”

Lastly for this section, the researcher will refer back to an earlier quote from Justin, when he noted, “For therapy, the role playing and interaction with the couple is important, and for that video is needed.” This is a therapeutic technique whose effectiveness is heavily influenced by the medium being used.

In the literature: theories & technique

When the process of this current study started, there was very little literature about Internet-based Family Therapy. Of the literature that was out there, most of it is speculative in nature and not based on research of the subject. Other articles are written by practitioner’s personal experience and written in the style of an editorial piece. There is beginning to be new literature on the topic that is based on research. This newer batch of articles talks about specific theories and techniques.

One study did a randomized controlled trial of an Internet-delivered family cognitive–behavioral therapy intervention for children and adolescents with chronic pain (Palermo, et al. 2009). Another studied family-based Problem Solving Therapy on-line
(Wade, et al. 2006). Derrig-Palumbo and Zeine (2005) wrote about Rational Emotive Therapy, CBT, and Solution Focused therapy used on-line and also dealt with different techniques, such as building rapport, giving feedback & dealing with transference issues. CBT seems to be one of the more popular theories to study the practice of on-line and that tends to be associated with individual work, granted, individual work is a significant part of many marriage & family therapists’ practice. (Bell, 2007; Klein, et al. 2006).

This current study did not glean much in the way of specific therapeutic techniques. A study done by Pinsof, et al. (2012) tracked a couple through the process of Internet-based therapy and examined different phases (assessment, planning, tracking, termination) and some techniques used (exploring alliances and family of origin). More of this kind of study will be welcome to the field.

Core Theme 6: The Main Concerns Are Confidentiality, Crossing State Lines & Harm To Self

The final theme was all about ethical issues in Internet-based Family Therapy. The participants hit upon many of the concerns discussed in the literature. Their thoughts, based on experience, put a little more flesh on the issues because it is not pure speculation. The main ethical topics covered were confidentiality, crossing state lines, and harm to self or others. Confidentiality or privacy was often mentioned first. As the reader will see, sometimes the issue of state or international lines gets combined with the issue of harm to self or others to create a particularly sticky situation. There is also discussion of contraindications and informed consent at the end of this section as they were issues also cited by the participants.
**Confidentiality**

Often the first ethical concern people bring up with Internet-based Family Therapy is confidentiality. Are the connections secure? Is the data locked down and encrypted? How do we protect privacy on-line? The research participants spoke to these questions:

Edith: Confidentiality is the biggest concern. There is such variability on whether or not the connections are secure.

Natalie: confidentiality is another one

Natalie: you are not sure who else is in the background

Andrea: Privacy of information

Steven: Persons seeking 100% anonymity have a real opportunity to present themselves as...someone else...different gender/race/religion, etc

Steven: Many Military people are terrified of their issues being known on base...for fear they will be stricken from certain hazardous duties, scuba diving, combat, demolition, etc

Aside from pointing out confidentiality as an issue, Justin explained what he does to address the issue (inform clients, educate about & offer encryption).

Privacy and confidentiality can be an issue, especially with skype or chat, like this. I inform clients that though I keep everything private and confidential, nothing on the Internet can be fully guaranteed to be private and confidential...Yes. I will offer clients some sites that use encrypted [encrypted] email. But, very few seem to really care about that...Most clients are quite comfortable using regular email, skype, chat. (Justin)

**State lines**

One of the most unclear and uncertain ethical issues related to Internet-based therapy is what to do about crossing state lines? With on-line work, it is very easy to virtually traverse great distances in an instant, so gas money and travel time are not barriers. Further, therapists that live on the borders of states may see clients from another
state. The therapy takes place in the state where the office is and where they are meeting (the state in which the therapist is licensed). It is less clear when it comes to on-line work where the clients may be present in another state during the therapy. The participants stated crossing state lines as a concern, but it should be noted that several of them, although aware of the concern, are doing Internet-based therapy across state and/or international boundaries.

Since one of the participants had done work with missionaries, the researcher asked her about this issue:

R: Mission work – obviously crossing state lines. That was one of the ethical issues that kept popping up in the literature. For missionaries, it may be less of an issue if they are temporarily out of the country and consider their home here, but have you found that to be an issue?

Edith: No, they are focused on their problems. It is an important issue, however. As we spoke about it on the [State Redacted] board, the ruling was that one would go by the state in which the therapist was residing. It isn't nailed down yet, however.

Steven made a point that the therapy may not only be across state lines, but international lines too. Yet again, he brings up an issue that seems to be site specific: the client or family could be dishonest about where they live.

BTW…we get callers from all over the world…may have been obvious to you, but we never know whether someone from Saudi Arabia, or across the street is calling…it makes cultural issues a lot more important and I have learned quite a bit, even about Americans…Middle Eastern countries are well represented, as well as the UK, Australia & Canada…I've had few from Central/Latin America or from the former Soviet bloc countries. Germany/Holland/Austria are frequent callers----OR people tell us that's where they are from. (Steven)

When the researcher asked Andrea about this issue, she brought up some more worthwhile ideas. The therapist can avoid the issue altogether by not seeing people
outside his or her state or can see them under a different designation besides therapist.

Finally, one can refer to someone local for the client.

**R:** Do you 'see' people from out of state?

**Andrea:** No, not in most cases. Just too dangerous for my license

**R:** I noticed in the informed consent that Thx is viewed as taking place in your state. Is that right?

**Andrea:** Once in a while when a personal has come to me through a referral, or I have formed a relationship with them before I found out, I have seen them under "expert advice" disclaimer

**Andrea:** But only for people who were more coaching/life coaching oriented.

**Andrea:** I had a person from another state obviously suffering from an emotional disorder. I reached out to my network and found some names for her to call in her state

*Harm to self or others*

Another important ethical issue is, as Andrea puts it, “missing signs of suicidality.” Not only missing those signs, but what happens in the event of an actual threat of harm to self or others? There was an intriguing story that Steven shared, providing a couple of incidents that help shed some light on the difficulties with this topic. The seeming disjointed nature of conversations through text-chat is illustrated once again in this exchange:

**R:** How would you handle threat of harm to self or others if the person is in another state/country and you only know them as 'sadgirl_372'

**Steven:** [site redacted] provides a link to get the clients personal information…we are required to input a reason for viewing it..."Suicidal/Homicidal comments" or whatever…then we are given the Name & Address…that THEY input

**Steven:** I had one female remove her contact info and I was not able to make a referral. I found out later that she was a habitual attention seeker
Steven: However, I did call the police in a small town in Ireland after a paid client told me she had downed a bottle of sedatives while we were chatting and that she was going to get off the computer to go die…

R: In trying to be circumspect on the topic, I guess one could argue that face to face clients could give false information too.

Steven: Got her address information…Googled the police in the little town she was in and got the number…BTW in most countries the POLICE are not called police, they are GUARDIA, CONSTABLES, etc

Steven: Then I had to learn how to place a call to Ireland…foreign countries have access codes we must dial in the US to reach that country…and that isn't given by the caller

R: Wow

Steven: YES they could lie, however, insurance use seems to preclude possible false identity issues…and face to face makes it harder to claim to be the opposite sex, etc

R: True

Steven: So it took me at least 30 min to place the call

Steven: They said they will "Send a Brigade Straight Away"

Steven: In that instance, the therapist should be much more concerned about the safety of a client than litigation and ethics (I guess that's always true).

Steven: Right…but how about people sharing ID's? Paying for someone else's therapy and kids using parents account…not supposed to happen but can't be policed…and I could send the police to the address on file, which may be for mom, dad, grandma that lives in a different city…

R: Good point

Steven: "I had a call from [hypothetical client] at XXXX" and she threatened suicide…here it was Tracy's babysitter calling from HER house 10 miles away…

Steven: Imagine the police wanting to investigate ME for a false report…

Steven: "You told us [hypothetical client] made the suicidal comment"

Steven: We would have some explaining to do
Steven: OR, how about the caller calling from work, the neighbors, the library…and we only have their billing address or info they input which wouldn't be for where they are at

Stories like this could be enough for some therapists to shy away from any Internet-based therapy, much less out of state or out of country.

_Contraindications and informed consent_

Aside from the ethical concerns mentioned as part of the theme, contraindications and informed consent were also addressed. They are both discussed below.

There were not many comments about the idea of contraindications in therapy as they relate to ethics aside from issues discussed earlier about client types that should not be seen over the Internet. Justin had a few observations to share on this topic. It may not be very evident early on that the case is inappropriate for on-line work.

R: Are there any populations or presenting problems that you would consider contraindicated for Internet-based therapy?

Justin: severe mental illness, suicidal, autism…those are a few that I would refer to local community supports

R: So, more severe cases?

Justin: yes…but the demarcation between what is so severe that it can't be dealt with on-line sometimes does not become evident until you've been working them a bit on-line

There were a few lines of discussion on a related topic, then we revisited this issue.

R: Going back to a response above, if you discovered that something was more severe after beginning therapy, how would you handle that?

Justin: Depends on how much I know about the person…age, family, social supports…If I know the town or city they are in, I will google some supports available there and recommend those…If I know nothing, then I state that I am not capable of helping them on-line in this context and encourage them to seek local assistance
The final issue under this topic of ethical concerns is informed consent. When interviewing Andrea, the discussion was about the need to build trust on-line:

R: How do you go about accomplishing that?

Andrea: So I make sure they know informed consent, can verify my credentials etc.

Letting the client know risks and benefits at the outset helps them understand that the therapist is someone that has their interest and safety in mind. In journaling, the researcher made a note about the way a site is set up and what that has to do with informed consent.

There are some therapy websites that require the therapist’s credentials to be verified and posted on the site. This seems like an important part of the informed consent process for the client. (Journal)

Finally, Edith had a different take on the issue which seems to assume responsibility on the part of the client or family.

R: Do you make the clients aware of these risks & pitfalls at the outset?

Edith: Not the ones within their control; such as interruptions from others and not having access. I do talk about confidentiality. We don't talk about internet crashing. That is just a known risk. I can see that it would be helpful to talk about all of it.

This statement points to the need for a therapist to carefully consider what items need to be included in the informed consent, taking into account that there are the normal therapeutic issues as well as some specific to Internet-based Family Therapy.

In the literature: ethics

Most of the literature related to ethics is not empirically based research. However, people endorse the concept of creating guidelines for how Internet-based Family Therapy practice should work (Finn & Banach, 2002; Montgomery & Ritchie, 2002; Negretti &
Wieling, 2001). Some suggested guidelines are particular to video conferencing (Mielonen, et al., 2002; Zipper, et al., 2000). In Chapter II, the researcher pointed out that codes of ethics from different organizing bodies like AAMFT and state boards are starting to address Internet-based Family Therapy ethics. Some writers recognized the need for this and were calling for it a decade ago (Jenciüs & Sager, 2001) and now it is starting to be addressed. As noted in the literature review, AAMFT (2012) created specific ethical guidelines for on-line work and they did an entire Family Therapy Magazine issue dedicated to Internet-based Family Therapy in 2009. Some articles talk about ways to be HIPAA compliant on-line through the use of encryption (Anthony, 2011; Nagel, 2011). Kazal & Conner (2009) said that fears of liability and malpractice have not been realized. Although that article was relatively recent, the more popular and widespread use of Internet-based Family Therapy could bring with it different types of litigation.

**Summary**

This study brought some rich insight to some varied topics that one needs to consider if they are interested in doing Internet-based Family Therapy. It is important to make sure that the site being used to do family therapy is one that will facilitate the therapeutic process. There are different issues that come with doing text-based work, video-based work and a combination of the two. The participants indicated that video is highly recommended. Some clients may not be right for on-line work – particularly more severe clients; others may be a good fit. The dynamics are impacted by how many clients are involved in a given session (i.e. individual, couples or family). The power differential appears to be affected by the medium, while anonymity is an important issue. There are
quite a few concerns that arise when you compare F2F and on-line work. There are some positives and some drawbacks. There is even the question of whether it counts as family therapy at all. The consensus is that F2F work is preferred, but when there is no other alternative, Internet-based Family Therapy may be a good choice. According to the participant experts, theories are used in much the same way on-line as they are in F2F, although some may not be well suited for the medium. The techniques used deal with a completely new set of issues because of a lack of or diminished set of non-verbals. Finally, ethical issues are a concern for this relatively new field of Internet-based Family Therapy. The three main issues were confidentiality, crossing state lines, and harm to self.

Because of the different ethical concerns, there was an additional round of interviews that focused on some of the questions related to ethics. These will be discussed in Chapter V.
CHAPTER V
DISCUSSION

This chapter includes responses from the final interviews (see Appendix D) with the participants. There were four topics covered having to do with ethics, standards, on-line limitations and self-harm issues. This chapter also addresses topics traditionally covered in a final chapter for a dissertation. The limitations of the study are pointed out (the use of on-line interviews and the particular methodology used). There is also a discussion of the findings, which includes a comparison to the Haberstroh (2002) study discussed in Chapter II. Considerations for therapists and directions for future research are discussed. Lastly, the researcher talks about the impact that the study had on him, personally.

Final Interviews

In Chapter III, the researcher wrote the following: In Heuristic Inquiry, the researcher is open in searching into a problem. This can lead to finding more literature, other people, institutions and more data collection. It permits a shift in methods to allow for the richest collection of information. The goal is to dynamically pursue knowledge. The data is collected and documented with descriptions, dialogue, metaphors, analogies and anything that gives a clear, accurate, and full revelation of experience (Douglass & Moustakas, 1985). After collecting the data from the initial interviews and e-mail follow-ups and subsequently writing Chapter IV, the researcher conferred with two experts (for
the expert check) and it became evident that there was a need for further data collection. Four new questions were developed and a final round of interviews was conducted.

The questions that were asked to the participants were as follows: 1. What ethical dilemmas might arise with this kind of treatment? 2. What standards do you abide by when using this kind of treatment modality? 3. What are the limitations of Internet-based therapy? 4. How do you handle threat of harm to self or others on-line? Only four out of the five participants were able to take part in this segment of the study. Natalie was unable to do an interview because of other time commitments. Edith, Justin, Steven, and Andrea each participated in one final on-line interview. The results of those interviews are below.

**Ethical dilemmas**

When the participants were asked, “What ethical dilemmas might arise with this kind of treatment?” they were able to give more nuanced answers, going beyond confidentiality, state lines, harm to self and others, contraindications and informed consent (although, some of those items were revisited). They talked about things like the lack of presence when not in the same room together, having the client’s welfare (i.e. safety, confidentiality, etc.) in mind, maintaining the honor of the profession (i.e. doing quality work), and proper representation and advertising of on-line services.

Justin suggested that the “most common and underlying dilemmas with on-line counseling is the lack of ‘reality.’ That is, a provider is dealing in a ‘virtual’ setting…In email and live chat there are few clues as to the mood other than the words.” This virtual setting makes it that much more important to be cognizant of the choice of words & use of descriptive language. Edith adds that the therapist needs to make sure they have the
client’s best interest in mind by not trying to multitask during sessions. Also, they may be
less attuned because of “the hurdles of being on-line.”

Another could be advertising. The client may think they are getting the same
services on-line as they are getting face to face, but experience a disadvantage
when they meet with the therapist on-line. This is a "possible" dilemma, as
therapy on-line can be done well. It would only be if the therapist is not delivering
as quality a product as they do in person. (Edith)

Related to this idea, Edith also said that making sure to offer a quality product would help
protect the profession. She was speaking to the idea that the family therapy work done
on-line needs to meet a high standard, so that work done in the name of family therapy
does not give family therapists a poor reputation.

Andrea supported this idea of a “quality product” by saying there is a need to
uphold therapy standards like ensuring privacy. She also mentioned that Skype, although
secure, is not HIPAA compliant, suggesting that therapists need to use a HIPAA-
compliant service. Edith noted that the line may not be secure, but even if the service is
HIPAA compliant, “Others could be listening in the same room,” on the client’s end.

The issue of state lines was discussed in Chapter IV and there were differing
views on the matter. Andrea said, “It’s illegal to practice outside your state, but not all on-
line therapists or services stick to their own state. That is a potential ethical dilemma both
in their own state and in the state they choose to practice in.” Edith recommended
researching the state laws for your state and the state of your clients thoroughly. It is
feasible that, for example, the state board of Tennessee might not have a problem with a
Tennessee-based therapist doing on-line work with a client that resides in Ohio, but
Ohio’s state board would have a problem with it (thus, a “potential” ethical dilemma both
in the their own state and the client’s state, as Andrea stated)
Another issue that Steven brought up was that of a client’s true identity. He points out that a client could be using someone else’s credit card information. The therapist is relying on the client’s honesty. One could suppose that this has the potential to happen in person, but seems less likely.

Steven also discussed an issue that, once again, seems to be related to the way a therapy site is structured. For sites that are structured this way, it does seem like an ethical issue. He said that, “paid time limitations,” are a problem (i.e. a session getting cut off when the paid time is up), because the therapist is more likely to pander to a client, give a ‘soft shoe response’ and try to keep them talking or throw out an extra question to prolong the session for an extra 10 minutes. As mentioned in Chapter IV, there are similarities to these issues in F2F work. The difference is the therapist having less control over how much time is allowed, etc.

There were a couple of comments on ethical issues that foreshadow some of the other questions that were asked in the final interview and will be discussed later in this section. Justin said that there are few clues about congruence (i.e. words matching body language). He also suggested this could be a positive if it led a client to be more willing to disclose. Justin brought up the threat of self-harm and how the therapist deals with it. Andrea said that the therapist needs to get necessary client information so as to be able to provide emergency services if need be. She pointed out that we cannot ethically provide anonymous services – there is a need for real names and addresses at a minimum. Again, the topics in this paragraph are discussed in further detail in following sections.

There seems to be more overlap with ethical dilemmas than there are differences between on-line and F2F work. Edith pointed to this after answering the question by
stating, “Other than those, I don't see much difference between ethical dilemmas in person or on-line.”

There are plenty of ethical concerns to be addressed in future research. As this section explained, participants added more ideas to what was discussed in Chapter IV regarding ethical issues. The “virtual” setting and lack of non-verbals is an encumbrance. Advertising practices need to follow ethical guidelines and make any necessary distinctions between in-person vs. F2F therapy processes. Therapists need to do quality work and not change their standards when doing Internet-based Family Therapy. The issue of crossing state lines still needs to be addressed properly. Therapists need to have a way to confirm clients’ identities. They also need to deal with the parameters of a website that cause a hindrance to the therapy process.

**Internet-based family therapy standards**

The second question for the final interview was “What standards do you abide by when using this kind of treatment modality?” The strong trend with the answers was that the expert participants use the same standards as they do with F2F work. There were a few specific standards mentioned and one set of standards specific to on-line work.

Justin’s first response to the question was, “The very same standards as would be employed when dealing with in-office, face-to-face clients.” Steven said that he strives to work as close to F2F standards as possible. Edith gave a similar answer and elaborated on it:

The AAMFT Code of Ethics…They are pretty pervasive in covering most standards of how to treat a client. My Christian faith undergirds everything I do in terms of treating people well, with grace, and ethically. I could also include my postmodern perspective of tolerance and the belief that there are within each of us the resources to do what we need to be healthy. That also stems from the belief that God's image is in each of us. (Edith)
Justin said there are “no real differences in the basic standards of treatment or service whether in person or on-line except maybe dress,” because (at least without a web cam), there is no need to worry about appearances. There are many ways that this statement is true. For instance, regardless of modality, ‘do no harm’ is top priority. Lastly, Andrea said she abides by the following:

The ethical code of the ACA, and the International Society for Mental Health Online's Suggested Principles for the Online Provision of Mental Health Services. This includes things like - providing a clear explanation of what to do in the case of technology failure, screen for suitability for on-line counseling, clearly establishing a "turnaround time" for asynchronous communication, among other things. (Andrea)

Specific standards Justin mentioned were privacy, confidentiality, using evidence-based interventions, and advertising appropriately. Steven said that when a client controls the time and mode of therapy (yet again, referencing site structure), normal standards cannot be adhered to.

In sum, the participant’s responses about standards, they said that the standards used on-line are mostly the same as those used in F2F work. They cited professional organization standards, ethical codes and one on-line-specific set of standards.

Limitations of Internet-based Family Therapy

“What are the limitations of Internet-based therapy?” was the third question that participants were asked. Nonverbals, a lack of “presence,” misunderstandings, properly assessing severity and other such issues were mentioned by participants when answering this question.

The greatest limitation in my opinion is that you don't have the same sense of presence. It's an understanding you get immediately when you are in the same space as someone. You know if they are happy, sad, angry, good, evil, etc. You, of course, can read these things on-line--moreso [sic] with video skype than with
text or email--but it is a qualitative difference. They also get a deeper understanding of your care for them as they are with you. (Edith)

According to Justin and Steven, there are no visual cues or body language with e-mail and text chat, but as Justin points out, “this limitation need not subtract form the effectiveness of the intervention.” Steven also said that the therapist can not determine if someone is manic over text and that if you do not have a history or records for the person, there is no way to verify a diagnosis. Though, a therapist could get records with a signed release and have a previous therapist send documents, just as in F2F therapy.

Edith suggested another limitation is that with asynchronous communication, there may be misinterpretations and you do not have the ability to immediately correct it. “It can do a lot of damage before you can address the misunderstanding.” She also said that it is not just missing what is communicated, but missing what is not communicated. “For example, when the client is saying one thing, but obviously thinking another thing. You won't get this with the email or texting and may not read it as easily with the skype.”

A therapist cannot read the mind of a client, whether F2F or on-line, but the non-verbal communication helps give context and clues and sometimes they do not match up with the content of the words. This seems to be what Edith was referring to. She also said that she likes to use humor in session, but that it gets hampered in the on-line setting.

Steven reiterated the idea that Internet-based Family Therapy is best as an adjunct to more standard interventions (F2F). Edith made a good point about a qualitative difference with F2F work by saying, “when a person is really distraught, sometimes it is comforting just to have someone with you. You can't replicate that on line. It goes back to presence.”
There were some more answers given about practical limitations with on-line work. Andrea said that ‘distance is less optimal’ when you are dealing with the threat of suicide. She also mentioned the following (which could be seen as ethical issue:

It cannot work well for people who cannot successfully use the computer to interact, whether that's because they are too young, not able to have the cognitive processing for talk therapy, or because English is not their first language. Due to the possibilities of misunderstandings even among those who are well-suited to Internet-based therapy, it isn't a good match for those are less suited for the medium. (Andrea)

Justin harkened back to the idea of contraindications by saying severe mental disease/disorders like schizophrenia, borderline, and self-harm can’t adequately be treated on-line. He said they can be, “discussed, but not really ‘treated’.”

A few more practical limitations were mentioned. Edith said that differing time zones can make it like a ‘circus trying to reschedule’ and that there can be technical issues like an echoing that can occur with certain hardware/software setups. Andrea said, “Technology can provide challenges at times, as well, delaying start times to start a video conference if the computer has issues. If that happens too often it can be detrimental to therapy.”

With this section, participants answered the question of limits to Internet-based therapy. There is a lack of body language and facial expression, hindering communication. There may not be a timely response when doing asynchronous communication. There is not as much ability to simply “be with” a person during suffering (i.e. you cannot replicate the “presence” that is there in F2F sessions). Additionally, more severe problems cannot be properly dealt with on-line. Lastly, there are practical issues like time differentials when the therapist is not in the same time zone as the client (possibly even if they are in the same state).
Handling harm to self and others

The final question for the participants was, “How do you handle threat of harm to self or others on-line?” Yet again, there was a common thread that suggested it should be handled with a similar protocol to the way it is handled with F2F clients.

I first try to screen out anyone who might be actively suicidal, and as soon as I see signs (if any) I try to find a local source of care as well. Before someone begins counseling with me, they must sign a release stating that they realize that I cannot provide 24-hour availability and that the protocol for suicidal thoughts is that they first call 911 and take care of themselves, and then later contact me for supportive care. If a person becomes suicidal while I am already treating them, I would call their emergency contact, if I am released to do so, and if not, call the police. With all my clients I work on having a multi-faceted support network to include friends, family, coworkers, and more as well as myself. (Andrea)

Steven said that, “attempts are made to treat it as you would doing face to face.”

Justin said that if he had a suicidal client, he would reiterate the informed consent and follow through with a police report. He said that gathering client information ahead of time makes contacting the authorities ‘not an obstacle.’ Edith said she would keep the client on-line and call someone in his or her area. She said it is important to get the person’s address with the intake questionnaire. She also said that she handles threat of harm to someone else the same as she would in person.

You assess the level of danger and make a judgment call as to whether it needs to be turned over to the authorities. State laws differ on whether you are breaking confidentiality or not, so if there is a risk, you need to look into the laws of the state of your client's residence. (Edith)

Justin said he handles threat of harm to self by strongly encouraging clients to contact a local therapist, an emergency room or a national hotline (for which he has the number readily available). Steven revisited the ordeal that was discussed in Chapter IV about a client that took a bottle of pills and told him she was going to die. He recounted how he had to look up the number for the local ‘Guardia’ (police) and figure out the international
telephone prefix, etc. He ended with a powerful and sobering statement by saying, “I often wonder if she died.”

To summarize the responses for how participants dealt with self-harm and duty to warn issues, they use the same protocol on-line as they use with F2F clients. The main difference seemed to be with clients that are outside of state or international boundaries.

Summary of final interview

The information gathered from the final interview helped reveal a little more about the concerns that an Internet-based Family Therapist has to deal with. The ethics, standards, limitations and dealing with self-harm definitely have some unique issues, but as the participants often pointed out, there seem to be more similarities than differences between on-line and F2F work. There were more differences that had been addressed in the original interviews and subsequent e-mail follow-ups. They did address some unique challenges regarding standards, ethics, limitations and dealing with self-harm. After answering these four questions, Edith said, “the focus has been on the negative, but I'm sure you have a lot of information regarding the positive aspects.”

Limitations of the study

The purpose of this study was to gain an understanding of the phenomenon of Internet-based Family Therapy as well as the advantages and disadvantages of conducting such therapy. Five participants, each that have experience doing Internet-based Family Therapy, were interviewed. The transcripts of those interviews were analyzed with phenomenological methods to see how those therapists experienced the phenomenon of Internet-based Family Therapy. The findings were discussed in Chapter IV, with additional material already covered in this chapter.
The current study was a qualitative study. By the very nature of qualitative work, it is not intended to be generalizable on a grand scale. Rather, it is exploratory in nature. At best, the reader may get ideas of directions for further research. The aim of this study was to understand the perspective and experience of five therapists that practice Internet-based Family Therapy. In addition, there was a desire to know how these experts defined Internet-based Family Therapy and see what they considered to be the main presenting issues for Internet-based Family Therapy. Although there were some themes generated, there is no guarantee that it would be the same themes had it been a different set of five participants.

As has been stated, the purpose of the study was to learn more about the process of Internet-based Family Therapy. This study was not intended to create a grounded theory of Internet-based Family Therapy the way that Haberstroh (2002) did. This study was also not intended to create recommendations for ethical guidelines or evaluate the effectiveness of Internet-based Family Therapy. To do so would entail a much larger study involving actual clients over a long period of time with follow-up evaluations. The study would also need to be more quantitative in nature.

Another point to be made about qualitative work is that it is subjective by nature. As mentioned earlier in this dissertation, the fact of subjectivity was intended to be overt. Part of the research design included my personal experience of interacting with participants in the on-line setting and journaling thereof.

One more note is that this study is about technology – a rapidly changing field in and of itself. The researcher pointed out in Chapter II that some studies were obsolete because of the focus on particular technologies. The aim of this study was to focus on
principles that transcend a particular type of technology. There seems to be a fair chance that multiple on-line mediums will be around for some time to come. The phone has been around for much longer than e-mail, text-based instant messaging or video conferencing and yet phone therapy still occurs today. There are synchronous and asynchronous modes of text, voice and video and combinations of each. My assumption is that video will start to overtake text-based Internet-based therapy. If indeed this happens, much of the current study will start to become less relevant. In addition, there may be technologies developed that could make even our current understanding of video chat become obsolete.

Lastly, there was a slight hindrance in the final round of data collection since one of the participants was unable to participate. Each participant shared rich data and Natalie’s contributions were missed since she could not do the final interview.

*Online interviews*

Just as Internet-based therapy is relatively new and has scant research, the act of doing research and interviewing on-line is not well studied either. Every limitation that is sited in Chapter IV (e.g. lack of non-verbals, technical difficulties, etc.) could also be considered a limitation to the method of research. What stands out to me about the interviews is that each of the participants had confidence and strong opinions about doing on-line work, based on their personal experience. The interviewees seemed open and honest and passionate about different topics. They each understood the importance of providing quality care in the on-line setting. The participants expressed themselves well and their comfort level with the medium of on-line text chat was evident.

Participants ended up having to be recruited from multiple websites. The researcher believes this added to the richness and diversity of experiences that were
shared. The potential for using exclusion criteria was mentioned in Chapter III (i.e. Only AAMFT members, only LMFTs, etc.). The researcher did not end up needing to use the exclusion criteria because the sample size was adequate. Had those criteria been used, the results might be different.

_Critique of methodology of the study_

Since the study was specifically about family therapists that do on-line work, by definition, anyone that qualified to be in the study had access to the Internet. Therefore, there was not a concern about excluding anyone because the interviews were done on-line. On the contrary, the online setting opened up the potential pool of clients because there were no barriers of physical distance. Also, there was not much concern regarding confidentiality with these participants because they were not therapy clients talking about their therapeutic issues but rather therapists commenting on a process and a medium.

Regarding the use of Excel as a research tool, the researcher found the sentiment from Swallow, Newton & Lottum (2003) to be accurate. It was, indeed, simple and robust and obviated the need to learn more specialized and complicated software. It was much like a digital version of using note cards to organize and sift through the data. Even with this program, every choice creates a limitation in a study. Even with a decent sized computer screen, the data cannot be laid out in the same way you can take a set of note cards and spread them out on the living room floor to get a bird’s eye view of many data points at once. The researcher did get to experience that during the Chapter IV composition since he used note cards to organize the flow of the narrative.

Using the very medium (on-line text chat) that was being studied made for a richer experience for the researcher. There were issues that arose that the researcher
might not otherwise have seen. For instance, he was mistaken about the time difference with one of the participants and had trouble with the scheduling. If he had done F2F interviews, he would not have noticed the strange cadence that occurs with text chat (some things get said out of order, etc.). These very issues can rightly be called limitations of the method, but at the same time, they informed the journaling and immersion aspects of the study.

The researcher chose to do text-based interviews because the literature indicated it was the most prominently used medium for Internet-based therapy. Going forward, he would be more interested in video conferencing when conducting interviews for research. A limitation is that there was no audio or video involved. Generally, more information can be expressed verbally than by one person typing, then a second person reading, typing out their response, sending it, etc. However, it was nice to have instant transcriptions from the interviews since they were text based. During the interviews, it was also nice being able to see the responses and re-reading for clarification.

Summary of limitations of the study

There were multiple limitations to the study. Because of the small sample size, the information is not generalizable. This study explored the phenomenon of Internet-based Family Therapy, but was not intended to establish ethical guidelines or measure efficacy. The work was inherently subjective. When studying anything related to technology, by nature, some information will become obsolete.

Doing on-line interviews caused limitations like a lack of body language and tone of voice. The participants did share useful information and it showed that they cared
about doing quality work. The use of participants from multiple sites turned out to create a broader range of data.

Doing interviews on-line made good sense given the nature of the study. Using Excel for organizing and analyzing data turned out to be a good choice, although it had some drawbacks. Lastly, using the chat medium had technical limitations, but also helped the researcher immerse deeper into the data since he was experiencing the medium first hand.

Discussion of the findings

In this section, the findings will be discussed. There is a comparison of the researcher’s findings and the findings of the Haberstroh (2002) dissertation. Considerations for therapists will be addressed and directions for future research will also be considered.

When doing the literature review, the point came out that answers the question, “Why should Internet-based therapy be done?” Authors of different articles supposed it should be done as a way to help people that would otherwise not be served. There are people searching for on-line help. Marriage and family therapists have an opportunity to serve and meet that need. If trained professionals do not, someone else will and there is no guarantee that the standard of care will be adequate. Even with family therapists doing the work, research needs to be conducted to better understand the standard of care that can take place on-line.

One article from the literature review (Jones, 2009) posited that Internet-based Family Therapy is not a new theory or approach, it is simply a medium with which to
deliver services. The participants echoed this sentiment when they made comments that they use the same theories and techniques that they use with F2F clients.

The literature indicated that the power differential is more equalized with Internet-based Family Therapy. This fits with participant responses that noted the power that clients have with this medium. Another point from the literature is that therapists forget to use the same business practices that they use in person. Edith and others spoke to this very concern during the final interviews (see Chapter V).

When comparing the ethical issues brought up by the literature and the participants from this study, there were some only mentioned in the literature, some uniquely addressed by the current study, and several discussed in both. The literature noted the importance of the fiduciary responsibility of the on-line therapist. There was warning to guard against inappropriate relationships with on-line clients. My participants did not mention those issues. Both this current study and the literature talked about the need for disclaimers, showing credentials, insuring confidentiality, giving a proper informed consent and the need to deal with duty to warn and self-harm issues.

The current study found that participants were not as concerned about crossing state or international lines as the literature would suggest people should be. Dee Anne Nagel (2001) suggested that one way to bypass the issue would be to simply practice within state lines. Interestingly, Slavich’s (2003) findings match up with the current study, because he found that many on-line therapists’ views of interstate practice didn’t match up with governing bodies. Governing bodies are still ambiguous on the topic.
Haberstroh comparison

The 2002 Haberstroh dissertation was used as a catalyst for this research. The findings of his research were summarized at the end of Chapter II. Those findings helped formulate the questions of the initial interviews. Part of the research design and analysis was to take the findings and compare them to the findings from Haberstroh. The following is a comparison of findings.

Haberstroh (2002) found that on-line text chat-based therapy compels clients to journal. My participants did not specifically speak to this idea, although the similarities to narrative therapy were mentioned. Both studies found that there are technical and interpersonal barriers such as the lack of non-verbals inhibiting disclosure and comprehension of each other’s meaning. Both studies suggested that Internet-based therapy is convenient (for both the therapist and the client) and that it is comfortable to interact from home.

The Haberstroh (2002) dissertation found that it is difficult to complete an assessment on-line. The participants from the study talked about the difficulty of assessing contraindicated, more severe issues, such as suicidality. One participant stated that this modality works best with people that are already adept at using computers. Haberstroh’s findings seem to back that up. Both studies also indicated that Internet-based therapy works best when the hardware and software being used are stable. It was also found (in both studies) that there is a need to wait during intervals of dialogue so that the therapist and client do not trip over one another during the conversation. The researcher had a participant mention that the anonymity allowed for a client that is doing
text-based therapy to feel more safety. Haberstroh also found that the text based environment provided safety.

There were a couple things found in the Haberstroh (2002) study that were not specifically noted with participants of the current study, although that is no indication that they would disagree. Haberstroh found that the therapy works best if the focus is on personal growth. Also, it worked well when the therapist responded reflectively (letting the client know that they were heard).

*Considerations for therapists*

There were some practical concepts discussed in Chapter IV that would be important for a family therapist to consider when approaching on-line work. It would be prudent to research the different options for an Internet-based therapy site and make sure there are as few hindrances to the therapy process as possible. Steven shared multiple issues that underscore that point, issues like time limits and the session getting automatically cut off once the amount paid gets reached, which would be jarring for therapists and clients. Therapist ratings are also set up in such a manner that a therapist feels the need to pander to clients is not good. It would be best to find a site that was created by therapists and not simply business people to make sure it was structured as much like F2F therapy sessions as possible.

The informed consent needs to address different issues that are unique to on-line work. As Andrea mentioned in a response during the final interview, this would include “providing a clear explanation of what to do in the case of technology failure, screen for suitability for on-line counseling, clearly establishing a ‘turnaround time’ for asynchronous communication, among other things.” This brings up the point that a
therapist should have contingency plans for when one technology fails (e.g. a storm cuts out the electricity).

There also needs to be thought about the type of computer hardware and software being used. It is important because the better the hardware and software, the less chance (at least on the therapist’s end) that there will be technical problems that get in the way of the therapy process. Having the right tools and quality tools allows a person to execute their desired tasks better and more effectively. Computer technology has advanced to a point that it is relatively inexpensive to have a computer capable of video conferencing. To illustrate this point, there have been smart phones capable of video conferencing for several years now. Having a good, fast, solid and reliable Internet connection is also an important consideration. Regarding software, there may be applications native to the computer operating system as well as “back end” software that powers the website being used. HIPAA-compliant encryption is needed for Internet-based therapy. All of these computer capabilities need to be considered on the client side as well, because even if the therapist has a powerful computer and a fast internet connection, it will still be an unacceptable experience if the client’s computer is 15 years old and they have dialup speeds.

If video chat is taking place, the therapist should put thought into their appearance and the room setup wherever they do their Internet-based therapy. They need to consider lighting, background and non-distracting clothing. There are also issues like the one Edith pointed out – looking at the camera helps the client feel that you are looking at them instead of at your computer screen (even though they are on the screen).
Therapists need to consider which clients are good candidates and which are contraindicated for on-line work. As pointed out in Chapter IV, the more severe clients seem to be best suited for F2F therapy. The therapist also needs to consider how they plan to compensate for and overcome communication difficulties with Internet-based therapy, particularly, the lack of nonverbal communication.

Regarding ethics, ensuring confidentiality is an important factor. The two other pressing issues are deciding whether to do and how to handle crossing state lines and how to handle the threat of harm to self or others. These issues will need to be more clearly dealt with by organized and accrediting bodies, such as AAMFT and state boards.

This section addressed several considerations for on-line therapists. They need to be aware of how the structure of the site they are using will impact the therapeutic process. Therapists need to have a well thought out informed consent. There are practical technical issues to consider. A therapist must be aware of contraindications and how to deal with them when they present themselves. Lastly, the importance of confidentiality issues in the on-line setting cannot be overstated.

*Directions for future research*

Areas that need to be studied more regarding Internet-based Family Therapy are theory, technique, effectiveness and studying the different mediums and what constitutes a good informed consent.

This is just one study with a sample size of five participants. Maybe the next step could be 100 participants. Also, these are participants that do Internet-based Family Therapy. There should be research done that gets input from actual clients on their experience of the phenomenon and their satisfaction levels with the medium. There are
many challenges still before us. There are many directions for future research on the topic of Internet-based Family Therapy.

The literature review found a few empirical studies that used CBT as a theory online. There need to be studies that are more systems & family therapy specific for the online medium. The participants suggested that theory and technique does not differ greatly from F2F to on-line modalities. These are the anecdotal opinions of five on-line therapists. This may turn out to be a valid point, but it does merit further study. It would be good to take different theories and different techniques and study them for efficacy in the on-line setting.

There could also be efficacy studies related to the different modes of communication (text, voice, video). The researcher mentioned, previously, that these could be isolated and studied separately, but there should also be studies to see how they work in conjunction with each other since, according the experience of participants, they may happen concurrently. There could also be research that focuses on young people. The participants indicated that young clients are more comfortable and even open up more on-line than they do during F2F sessions. At the moment, this is simply anecdotal evidence. It should be studied further.

In addition to efficacy studies, video-based therapy is new enough that it could still benefit from qualitative and exploratory studies to learn more about how it works. A study that used actual therapists and clients doing on-line video therapy could garner rich information about the medium.

Further research on a helpful, practical and effectively written informed consent would be beneficial to the field as well. There are some standards out there (like those
mentioned by Andrea earlier in this chapter), but an evidence-based approach to the topic would be good. For instance, it might be helpful to clients to explain the strange cadence of text-based Internet-based therapy, to guard against confusion and misunderstanding.

The research that we do should help inform AAMFT, COAMFT and others as they make decisions about policies, standards and codes of ethics as they relate to Internet-based Family Therapy. Another study that could be quite informative would be to research how many state boards actually address Internet-based therapy and specifically crossing state lines. Of those states that do, how many say that the therapy takes place in the state that the therapist resides in? People have made comments about these topics (the literature, this study), but solid information with a state-by-state comparison could be enlightening.

There are other questions that need to be addressed as well, like how will insurance panels handle (or rather, how do they handle) Internet-based Family Therapy? With all this research, we should have the aim that new information helps create a safe environment for clients and therapists alike. No therapist wants to be the reason new case law is created, and there are many potential ethical pitfalls with this relatively new medium.

As this section indicates, there are many different roads to travel regarding directions for future research. We need to understand which therapies and techniques work well. We need to understand the efficacy of the medium and compare F2F with text, audio, video and mixed modalities. Also we will need to address questions about ethics, standards, training, insurance and the like.
The impact of the study on me

This research was, by nature, a long process. I had some ideas and assumptions going into the study, partly based on the literature up to that point in history. I gained new insight from the participants as well as from my personal experience of using text-chat and e-mail for my method of communication with participants.

I did not consider the importance of the structure of the site being used to do therapy. I see now how important that can be. I also did not realize how rapidly video was “coming into its own” for Internet-based therapy.

I was less surprised about which clients were considered contraindicated as that seemed fairly intuitive. I had not considered the concept that there could be difficulty assessing for those contraindications on the front end of the therapy process. This could be fodder for yet another area of future research.

Another point that I had heard before starting the actual study was, “It’s better than nothing.” These participants reiterated that idea unanimously by pointing out that, yes, F2F work is preferred, but sometimes, Internet-based Family Therapy may be the only option.

Regarding theories and techniques, I was surprised to find that these participants considered much of the process very similar to F2F work. After hearing their descriptions, I could see how this holds true, particularly when using more cognitive based approaches.

As far as ethics are concerned, I came away with several (tentative) conclusions. First, the worry about confidentiality might be overstated. It is an important issue, just like it is with F2F, but that does not mean it is not doable on-line. Encryption software is
quite sophisticated and therapists just need to take the proper precautions and not be naïve. When hearing about state line issues, I came away thinking I do not even want to deal with crossing a state boundary because of having to deal with different state boards and multiple state laws. There are two exceptions that come to mind. The first is if the client lives in my state, but was out of state on vacation or some such reason. The second is if the client lived in my state, but was doing mission work and needed therapy as part of their support system. Finally, with the threat of harm to self and others, the participants said this could be handled in much the same way it is in person. If it turned out to be a similar frequency (which happens to be rare), I don’t think this issue would be much of a deterrent for doing on-line work.

Interestingly, in the months leading to the completion of this study, I have had three different requests to do Internet-based Family Therapy. In each case, the couple did not know that I was, coincidentally, doing a dissertation on the topic. One couple I am working with knew they were going to be unable to come for about a month because one spouse was in a music group that was going on a world tour. They did not want to miss any sessions. The second couple told me they plan to move to another state at the end of the summer and they did not want to have to change therapists. The third client said that she wanted her friend that lives in another country to see me and asked if I could do Skype sessions. One agency I contract with is planning to offer on-line services, but they are starting out cautiously and plan to only do Life Coaching at first to “test the waters.” They have several satellite offices in smaller communities around a metropolitan area, but are trying to find ways to provide for underserved client populations in more remote
areas. I believe I will be able to contribute to the process as the agency figures out how to implement these services.

As much as I have learned from doing this study, the request from actual clients for Internet-based therapy has had an impact on my thoughts about doing on-line work myself. In addition, seeing that an agency I work for is also seeing the need/demand from clients for these services tells me that more and more people are becoming aware of the opportunities we have to do this kind of work. I want to serve and meet the needs of my clients. This study will have a big impact on how I move forward with decisions related to doing Internet-based Family Therapy. In some ways, it has made me more cautious (e.g. the potential for dealing with crossing state lines), but it has also helped me feel more confident and informed about the field and the phenomenon. One benefit of practicing Internet-based Family Therapy, myself, is that I would be that much more informed and immersed in the phenomenon for doing research. It also opens up the range of research designs that I could do since I could be more than just an observer of the process.

One important way this study impacted me was bringing to my attention the need for so many areas of study and the need for different types of research related to Internet-based Family Therapy. As the reader can see from the ‘directions for future research’ section, there is no shortage of options for how to study this modality. There are many more questions than there are answers at this point. It is an exciting field to be studying. It is just beginning and it will be here for the foreseeable future.
Conclusion

This chapter addressed the limitations of the study, particularly, limitations of doing on-line interviews and the methodology of the study. The findings were also discussed, first by comparing them to Haberstroh’s 2002 study, then by looking at considerations for therapists and finally by discussing directions for future research. Lastly, the researcher addressed how the study impacted him personally.

The researcher is glad to have gone through this process and hopes that it is considered an adequate contribution to the field of marriage and family therapy and specifically to the field of Internet-based Family Therapy. He also hopes that it can be used as a launching point for future research on the topic.
REFERENCES


Caspar, F. & Berger, T. (2005). The future is bright: How can we optimize on-line counseling, and how can we know whether we have done so? *The Counseling Psychologist, 33*(6), 2005.


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APENDICIES
APPENDIX A

INTRODUCTION LETTER

Hello,

I am a doctoral student interested in Internet-based Family Therapy. It has potential to be a thriving part of our service delivery. I’m encouraged that people like you are helping to pioneer this avenue. I have done an extensive literature review and found the sources lacking regarding empirical research. I’m sure you would agree that solid research would only help improve the quality of such services.

I am conducting a qualitative study that specifically looks at the experience of family therapists on-line. I want to find out what the advantages and disadvantages are, what theories work well, which don’t, what issues are unique to seeing families or couples on-line (rather than individuals). I will be conducting interviews through text chat. If there is need for clarification, an e-mail may be sent with follow-up questions. The plan for the text chat is to use the interface already developed for mytherapynet.com. Specifics will be worked out over e-mail on setting up a time and method for the interview.

If you have done Internet-based therapy and have a license or specialty in family or couples therapy and would be willing to participate, I would greatly appreciate your help to further the literature in this promising method of service delivery.

Please e-mail me at tracydhall.2@gmail.com if you are willing and able to participate. You can simply put “on-line study” in the subject line of the e-mail and feel free to send any questions or comments. The time invested on your part will be minimal for the benefit to our field. More details about the study will follow if you decide to participate.

Also, if you know of any others willing to participate, please let them know and give them my e-mail.

Thank you for your time,

Tracy Hall
APPENDIX B

INFORMED CONSENT TO ACT AS A RESEARCH PARTICIPANT

TITLE: Internet based Family Therapy: A Qualitative Inquiry

INVESTIGATOR: Tracy D. Hall, MS
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Department of Counseling and Special Education
Akron, OH 44325
(330) 926-9505
tracydhall.2@gmail.com

DISSERTATION ADVISOR: Dr. Patricia Parr
University of Akron
Department of Counseling and Special Education
Akron, OH 44325
(330) 972-8151

DESCRIPTION: The objective of this study is to explore the experiences of therapists that engage in therapy with families and/or couples utilizing Internet technology. The information will be obtained initially from a text-based on-line chat with subsequent follow-up questions in an e-mail if necessary. The interview transcripts and e-mail responses will be analyzed and reported as part of a doctoral dissertation at the University of Akron.

Each of the participants will be interviewed in a text chat. Once they have completed the interview, there may be follow-up questions in an e-mail. The data collected will be analyzed.

For the first round of data collection there will be six open-ended questions. The participant should expect the interview to take 50 minutes to complete. The session will end sooner if questions are answered sufficiently before that time. Follow-up e-mail will be sent only once.

RISKS AND BENEFITS: There are no known risks or discomforts associated with this research.

By participating in this study, you may help the field of family therapy gain a better understanding of Internet-based therapy and begin to focus efforts towards improving services to future clients.
CONFIDENTIALITY: All identifiable information will be disposed of following the study. You will not be identified in any reports on this study. Records will be kept confidential to the extent provided by federal, state, and local law. However, the Institutional Review Board, and university officials responsible for monitoring this study may inspect these records.

RIGHT TO REFUSE OR END PARTICIPATION: A participant is not compelled to remain in this study and may stop at any time. The researcher or committee chairperson may also choose to stop the study at any time if it is indicated.

VOLUNTARY CONSENT FOR COMPLETION OF ONE ONLINE CHAT-BASED INTERVIEW AND A POSSIBLE FOLLOW-UP E-MAIL: Researcher, Tracy D. Hall, has explained all of the above said information and has sought to answer all questions pertaining to this material and the research study. Tracy D. Hall may be contacted at (330) 926-9505 or at tracydhall.2@gmail.com if any questions should arise. A participant who further wishes to address their rights as a participant in a research study may contact M. Sharon McWhorter, Associate Director, and Research Services at (330) 972-7666 or toll free at 1-888-232-8790. The participant agrees to take part in this study by typing their name (to serve as a signature) on this form.

_________________________________________  __________________________
Name of Participant                           Date

INVESTIGATORS CERTIFICATION: Researcher, Tracy D. Hall, certifies that he has explained to the above participant the nature, purpose and potential risks and benefits associated with participating in this study and has answered all questions that have been posed by the participants.

_________________________________________  __________________________
Name of Investigator                           Date

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APPENDIX C

FIRST ROUND INTERVIEW PROTOCOL

First off, do you mind sharing some demographic information? (age, ethnicity, gender, education, state of residence)

1. In your experience, what does Internet-based Family Therapy look like (the process, the number of people involved, etc.)

2. What are some specific concerns for family therapists regarding the Internet (technical issues, ethics, scheduling, client education)

3. What particular MFT/systems theories have you found fit well with therapy over the Internet?

4. Are there any populations or presenting problems that you would consider contraindicated for Internet-based therapy?

5. What advantages/disadvantages are there with Internet-based Family Therapy?

6. Is there anything that you would like to mention related to Internet-based Family Therapy not addressed in the previous questions?

If necessary, I may e-mail some follow-up questions.
APPENDIX D

SECOND ROUND INTERVIEW PROTOCOL

1. What ethical dilemmas might arise with this kind of treatment?
2. What standards do you abide by when using this kind of treatment modality?
3. What are the limitations of Internet-based therapy?
4. How do you handle threat of harm to self or others on-line?
## APPENDIX E

### DATA SOURCES

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<thead>
<tr>
<th>Time &gt;</th>
<th>Pre-Study</th>
<th>Round 1</th>
<th>Round 2</th>
<th>Round 3</th>
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<tbody>
<tr>
<td><strong>Researcher</strong></td>
<td>Journaling throughout (based off of literature review, pilot study, data collection &amp; experience with the medium)</td>
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<tr>
<td><strong>Participants</strong></td>
<td>Text-Based Interviews</td>
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<td>E-mail follow-ups</td>
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<td>Second E-mail Follow-ups (if necessary)</td>
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